

The President's Emergency Plan for AIDS Relief

FIVE-YEAR HIV AND AIDS STRATEGIC PLAN For United States-South Africa Cooperation

FY2004 - FY2008



Date approved by Chief of Mission: October 29, 2004

Date submitted to Global AIDS Coordinator: October 29, 2004

Revised: December 6, 2004

Date approved by Global AIDS Coordinator: January 13, 2005

TABLE OF CONTENTS

	PAGE NO.
EXECUTIVE SUMMARY	iii
ACRONYMS	iv
Section 1 INTRODUCTION AND BACKGROUND	1
Section 1.1 Vision	1
Section 1.2 USG Targets for South Africa	1
Section 1.3 The HIV and AIDS Crisis in South Africa	2
Section 1.3.1 Additional Indicators and Impact	2
Section 1.3.2 The HIV and AIDS Response to Date	3
Section 1.3.3 Constraints and Opportunities for Emergency Plan Implementation	8
Section 2 CRITICAL INTERVENTIONS	9
Section 2.1 Introduction	9
Section 2.2 Prevention	14
Section 2.2.1 PMTCT	15
Section 2.2.2 Abstinence, Be Faithful for Youth	16
Section 2.2.3 Prevention For Other Populations	16
Section 2.2.4 Blood Safety	18
Section 2.2.5 Other Medical Transmission of HIV	18
Section 2.3 Treatment	18
Section 2.4 Care	19
Section 2.4.1 Counseling and Testing	20
Section 2.4.2 Palliative Care	21
Section 2.4.3 Care for Orphans and Vulnerable Children	23
Section 3 SUPPORTIVE INTERVENTIONS	24
Section 3.1 Engendering Bold Leadership	24
Section 3.2 Stigma and Discrimination	25
Section 3.3 Gender Equity	26
Section 3.4 Achieving Sustainability and Human Capacity Development	26
Section 3.5 Strengthening Coordination and Collaboration	27
Section 3.6 Strategic Information	28
Section 4 CONCLUSION	29

APPENDICES

Appendix 1:	The Sociodemographic and Economic Context in South Africa
Appendix 2:	Availability of HIV and AIDS Services in 2003/2004
Appendix 3:	Prevalence by Province
Appendix 4:	Persons Living in Poverty by Province
Appendix 5:	Stabilizing Incidence of HIV in Adolescents
Appendix 6:	References

EXECUTIVE SUMMARY

Over the next five years, HIV and AIDS will create unprecedented public health and social challenges in South Africa with ramifications for the entire Southern Africa region. The five-year strategy to implement the President's Emergency Plan for AIDS Relief in South Africa outlines a robust response to these challenges, with the goal that by 2008 all South Africans will have access to a full range of prevention, treatment and care services.

The South African Government is implementing a balanced, integrated set of prevention, treatment and care interventions, with a strong emphasis on monitoring and evaluation. The approach focuses on strengthening the health system as a whole, and increasing the integration of VCT, PMTCT, treatment and care. Implementation emphasizes enhanced public-private partnerships and a network approach to service delivery. The harmony of South African and Emergency Plan goals and the unprecedented commitments of resources from both governments create real opportunities for collaborative and efficient programs.

The United States and South African collaboration will achieve our shared objectives through a disciplined program defined by seven principles.

- ***Principle 1: Support the SAG Program.*** The bedrock principle of the Emergency Plan program in South Africa is that implementation supports South Africa's Strategic Plan and Comprehensive Plan.
- ***Principle 2: USG Integration.*** All USG agencies with HIV and AIDS programs in South Africa jointly plan and manage all Emergency Plan activities as an integrated Task Force.
- ***Principle 3: Many and Diverse Partners.*** To maximize geographic reach and programmatic impact, the Emergency Plan program works with governmental partners at all levels of the public health system and with the full spectrum of NGOs, FBOs and private sector partners.
- ***Principle 4: Evidence-based Programming.*** In consultation with the South African Government and other local experts, Emergency Plan programs are selected and designed on a sound research base.
- ***Principle 5: Measurable Results.*** All USG-supported interventions will be rigorously assessed through regular accurate reporting and targeted studies to monitor the achievement of targets and assure high quality performance.
- ***Principle 6: Capacity Development.*** The United States will support the enhancement of human and infrastructure capacity to help South Africa achieve its health and social goals related to HIV and AIDS.
- ***Principle 7: Sustainability.*** Interventions are designed so that programs and service improvements supported by the Emergency Plan will be sustained and extended after 2008.

South Africa meets the essential conditions for Emergency Plan success: a strong government commitment to partnership at all levels, a tradition of public involvement and government transparency, a public and private health care network that can implement an effort of this magnitude, a dynamic academic environment, and a large pool of committed partners including NGOs, FBOs and private businesses. South Africa can fully utilize, efficiently and cost-effectively, all the Emergency Plan resources allocated to it in order to make substantial contributions toward Emergency Plan goals and toward improving the lives of thousands of South Africans.

ACRONYMS

AIDS	Acquired Immunodeficiency Syndrome
ANC	Antenatal care
APS	Annual Program Statement
ART	Antiretroviral therapy
ARV	Antiretroviral (drug)
BCC	Behavior change communication
CBO	Community-based organization
CT	Counseling and Testing
Comprehensive Plan	Operational Plan for Comprehensive HIV and AIDS Care, Management and Treatment, April 2003-March 2008
DOD	U.S. Department of Defense
DOTS	Directly observed treatment, short course
DSD	Department of Social Development
EC	Eastern Cape province
ECRTC	Eastern Cape Regional Training Center
Emergency Plan	President's Emergency Plan for AIDS Relief
FBO	Faith-based organization
FDA	U.S. Food and Drug Administration
FDC	Fixed Dose Combination
FS	Free State Province
GIPA	Greater Involvement of People Living with HIV and AIDS
Global Fund	The Global Fund to fight AIDS, Tuberculosis and Malaria
GDP	Gross domestic product
HBC	Home-Based Care
HCD	Human capacity development
HIV	Human Immunodeficiency Virus
HHS/CDC	U.S. Department of Health and Human Services, Centers for Disease Control and Prevention
HHS/NIH	U.S. Department of Health and Human Services National Institutes of Health
HSRC	Human Sciences Research Council
HST	Health Systems Trust
IDASA	Institute for Democracy in South Africa
IEC	Information, Education and Communication
ILO	International Labor Organization
KZN	KwaZulu-Natal
M&E	Monitoring and evaluation
MCC	Medicines Control Council
MER	Monitoring, Evaluation and Research Unit, NDOH
MSM	Men who have sex with men
NDOH	National Department of Health
NGO	Non-governmental organization
NICD	National Institute for Communicable Diseases
NIH	U.S. National Institutes of Health
NHLS	National Health Laboratory Services

OGAC	Office of the Global AIDS Coordinator
OI	Opportunistic infection
OVC	Orphans and other vulnerable children
PHC	Primary health care
PLWHA	People living with HIV and AIDS
PMTCT	Prevention of mother to child transmission
PGO	Procurement and Grants Office, CDC
RHAP	Regional HIV/AIDS Program (USAID)
SADHS	South African Demographic and Health Survey
SAG	South African Government
SANAC	South African National AIDS Council
SANBS	South African National Blood Service
SANDF	South African National Defense Force
SANGOCO	South African National NGO Coalition
STI	Sexually transmitted infection
Strategic Plan	South African National HIV/AIDS and STI Strategic Plan, 2000-2005
TB	Tuberculosis
UNAIDS	Joint United Nations Program on HIV/AIDS
UNHCR	United Nations High Commission for Refugees
UNICEF	United Nations Children's Fund
USAID	U.S. Agency for International Development
USG/SA	U.S. Government in South Africa
VCT	Voluntary counseling and testing
WC	Western Cape province

SECTION 1: INTRODUCTION AND BACKGROUND

Over the last decade South Africa has transformed itself into an egalitarian democracy, aggressively addressing social and economic challenges to reduce poverty and to redress the injustices of its apartheid past. In the same decade, HIV prevalence among South Africans of reproductive age has risen from less than 3% to an estimated 21.5% (UNAIDS 2004). With 5.6 million citizens infected with HIV (NDOH 2003 data) South Africa has more HIV-infected adults and children than any other country in the world (UNAIDS 2004). One quarter of the people living with HIV and AIDS (PLWHA) in the 15 Emergency Plan focus countries are in South Africa, with an estimated 75% of those infected in the early stages of the disease, showing few if any symptoms. Over the next five years, unless effective prevention and treatment programs are fully implemented, HIV related morbidity and mortality will increase dramatically. Given the size and regional importance of South Africa, HIV will create unprecedented public health and social challenges with ramifications for the entire southern Africa region.

Section 1.1 Vision

The vision of the U.S. – South Africa five-year strategy is that by 2008 all South Africans will have access to a full range of HIV and AIDS prevention, treatment and care services.

The vision of the U.S. – South Africa five-year strategy is that by 2008 all South Africans will have access to a full range of HIV and AIDS prevention, treatment and care services.

In South Africa, the Emergency Plan is implemented in full cooperation with the South African Government (SAG). Through collaboration with civil society, PLWHA, public and private sector partners, and other bilateral and multilateral organizations, the United States Government (USG) is committed to contributing technically and financially to the achievement of South Africa's 2008 goals in the fight against AIDS, and to strengthening the nation's public health system to provide a sustainable response that will mitigate the impact of the epidemic on the South African people. Our ambitious goals are achievable in part because South Africa has sizeable resources to meet the challenges posed by HIV and AIDS. With 38% of the GDP of sub-Saharan Africa and extensive health service and research expertise, the SAG is supporting a comprehensive and vigorous response. In this context, the vision of full access is realistic because the USG is contributing to a vibrant and expanding partnership that harnesses national and international resources to enhance a nationwide service delivery system.

Section 1.2 USG Targets for South Africa

As one of the 15 Emergency Plan focus countries that *collectively* will provide treatment to 2 million people with AIDS, avert 7 million infections and provide care and support to 10 million people worldwide by 2008, the Office of the Global AIDS Coordinator has assigned ambitious targets to the USG/SA team. By 2008, Emergency Plan support in coordination with the SAG will provide effective treatment to 500,000 AIDS

patients, avert over 1.3 million new HIV infections¹, and provide care for 2.5 million orphans and vulnerable children (OVC) and HIV-infected adults. An important initial SAG target repeated by President Mbeki in his 2004 State of the Nation address is that by March 2005, 53,000 HIV-infected individuals will be receiving ARV-based treatment. One of the USG's goals through the Emergency Plan is to help the SAG reach this target.

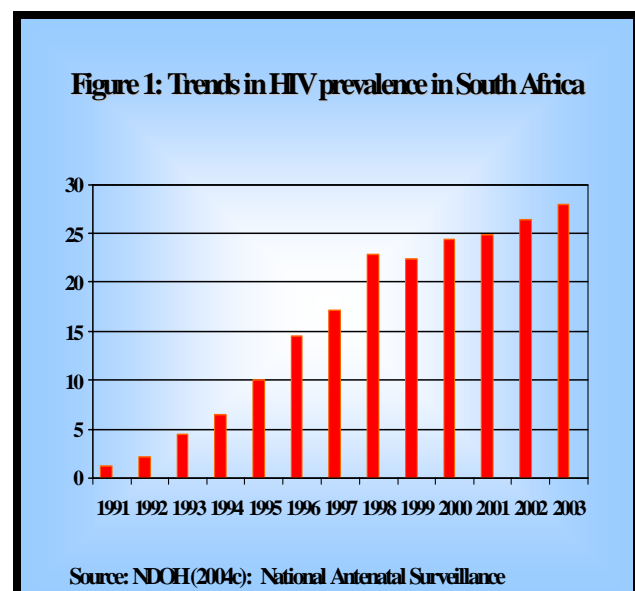
Section 1.3 The HIV and AIDS Crisis in South Africa

In the decade since the end of apartheid, South Africa has made impressive strides in child health, reproductive health, education, economic development, democratic governance, and political participation (see Appendix 1). During the same decade, HIV prevalence has grown rapidly, creating a generalized epidemic threatening all these hard won gains. As in most of Africa, HIV is transmitted in South Africa primarily through heterosexual relations, although other routes include perinatal transmission, unsafe medical and cultural practices, and men who have sex with men (MSM). Sex workers and their customers, people with sexually transmitted infections, incarcerated people, migrant workers, employees of industries such as mining, and MSM, are at greatest risk for HIV infection. The South African National Defense Force (SANDF) estimates that 23 percent of its soldiers are HIV positive, and other uniformed service populations (including police) are also at high risk.

Section 1.3.1 Additional Indicators and Impact

South Africa's generalized HIV epidemic is diverse, involving interacting sub-national epidemics. Both population density and HIV

prevalence vary markedly in different provinces and populations (see Appendix 2). While the rate of increase in HIV infections has declined since 1998, prevalence continues to climb (see Figure 1 and Appendix 3). HIV infection rates of over 60% have been observed among sex workers and in some border towns and other 'hot spots'. Over 1,700 South Africans become infected every day and morbidity and mortality associated with HIV will rise rapidly over the next three decades. The predicted demographic result is an unprecedented net *reduction* in the total population of more than five percent by 2025.



Health Impact. Increasing levels of tuberculosis, pneumonia and wasting are being widely reported as people infected years ago become severely immune-compromised. AIDS is the leading cause of death among adults, and accounted for 40% of under-five mortality in 2000. In the next decade annual HIV-related deaths are expected to rise from 370,000 to 500,000 per year. Already, up to 60% of hospital bed occupancy is HIV-associated, and, with 16% of health professionals infected, the health system's capacity to manage HIV morbidity will be increasingly compromised.

¹ Preventing 1.3 million new HIV infections by 2008 represents a pro-rated portion of the 1.8 million target for South Africa by 2010.

Economic Impact. AIDS predominantly kills economically active people. Research predicts that by 2015, South Africa's total labor force could fall by 21 percent. Depending on the industry sector, from 10 to 40 percent of employees already are HIV positive. A recent ILO study found that AIDS has caused a two percent loss in GDP over the last decade. As a result, the South African private sector has a critical stake in reducing the impact of HIV and AIDS.

Impact on Education. A recent study suggests that 16 percent of teachers are HIV positive and the Department of Education expects that within a decade teacher shortages will be "chronic," especially in poor rural communities. The impact is also felt among students affected by HIV who cannot pay school fees, are unable to attend when caring for sick parents, or who drop out when facing stigma and discrimination. For these reasons, or due to HIV mortality, large declines in primary school enrolment already are being reported in the most-affected provinces.

Impact on Communities, Families and Children. About half of South Africa's population is under the age of 15. AIDS will likely increase the infant mortality rate over the next five years by 26 percent. At the end of 2003, UNAIDS estimated that there were 1,100,000 South African children orphaned by AIDS (lost at least one parent). In 2002, 3.3% of South African households were headed by children (Shisana & Simbayi, 2002:106). Community capacity to sustain and

support OVC must be enhanced and pediatric AIDS treatment must be provided in order to mitigate the severe impact of HIV on South African families and on future generations.

Section 1.3.2 The HIV and AIDS Response to Date

The Early Years. During the 1990s, the SAG and active NGOs responded to the growing HIV epidemic with a focus on the prevention of transmission in the context of poverty reduction, particularly among urban youth and high-risk populations including mobile populations and migrant laborers. National communication campaigns helped raise awareness, provided prevention messages, and urged diagnosis and treatment of sexually transmitted infections. In addition, the SAG distributed male condoms, primarily through public health clinics. NGOs and universities advocated for government prioritization of HIV prevention, treatment and care, and

important research was undertaken on clinical and social aspects of HIV. Forward-looking businesses and parastatals took action to assist their employees. Unfortunately, these efforts were not enough to prevent a dramatic rise in HIV prevalence among most South African population groups.

The Status of the Three Ones. In 2000 the SAG created the South African National AIDS Commission (SANAC) to coordinate and guide the nation's response to the HIV epidemic. SANAC includes representation from 16 government

Table 1: HIV and AIDS in South Africa

People Living with HIV and AIDS (PLWHA)

Adults (15-49): 5,600,000**

Children (0-14): 230,000*

National adult prevalence: 21.5%*

AIDS deaths (adults and children) 370,000*

Orphans due to AIDS: 1,100,000*

Predicted population loss to AIDS by 2011: 5 million***

Sources and years of data: * UNAIDS (July 2004); ** NDOH 2003 Antenatal Surveillance; ***Bureau of Market Research

departments, civil society and the private sector, demonstrating the SAG's commitment to a comprehensive, multisectoral response. Consistent with the "three ones," SANAC, chaired by the Deputy President, serves as the "one" national AIDS oversight authority and the Country Coordination Mechanism (CCM) for the Global Fund.

In 2000 the SAG released the South African National HIV/AIDS and STI Strategic Plan, 2000-2005² (Strategic Plan), which called for an expanded response, including primary prevention, PMTCT, treatment and care. The Strategic Plan was developed through a participatory process that helped mobilize additional sectors of government and society. Strengthening HIV and AIDS services was called for within the context of the NDOH efforts to strengthen the public health system as a whole and the SAG's core principles of "access, equity, efficiency, quality and sustainability." The Strategic Plan was followed by the 2003 Operational Plan for Comprehensive HIV and AIDS Care, Management and Treatment for South Africa, April 2004-March 2009 (the Comprehensive Plan), which details a national program to provide a continuum of care, including AIDS treatment using ART, provided in district-focused service networks. These two documents mandate a balanced, comprehensive program organized into four key areas of intervention: (1) prevention; (2) treatment, care and support; (3) research, monitoring and surveillance; and (4) legal and human rights. They call for integration of public and private sector resources, community participation, involvement of PLWHA, and incorporation of traditional medical practitioners. They also emphasize the synergistic benefits expected from integrating prevention, treatment and care.

Taken together, these policy documents provide the single policy framework called for in the "three ones" approach. Having endorsed the "three ones" the SAG also is working toward a unified monitoring and evaluation framework, and it has defined standardized indicators to which all partners are expected to contribute. Every element of the USG HIV and AIDS program in South Africa is implemented in concert with the NDOH, in alignment with the Strategic Plan and the Comprehensive Plan and in support of the government's monitoring and evaluation strategy.

Multisectoral Governmental Response.

Because HIV in South Africa affects all sectors of society, nearly every element of the SAG is now engaged in the response; every National Department is required to have an AIDS focal point and budget and many are partners in the USG effort. The Department for Social Development (DSD) plays a leadership role in funding services for OVC support and in assuring their health, economic and educational needs are met. The Department of Education has incorporated HIV prevention, care, stigma, and gender issues into its national "Life Skills Curriculum," reaching 72% of youth with AIDS education. The Department of Correctional Services (DCS) is introducing comprehensive HIV services into its 239 correctional facilities, and the South African National Defense Force (SANDF) has responded with a vigorous prevention, treatment, care and research program. The National Treasury is making unprecedented investments of national resources in the HIV and AIDS response, including large increases for the FY04/05 budget to over R2.1 billion (\$320 million). Such concrete actions in response to popular demand and mandated by the highest level of government continue South Africa's leadership in implementing a multisectoral approach to HIV prevention, treatment and care.

² The NDOH is currently preparing a tender for a review and assessment of the current 5-year strategic plan, and the development of the follow-on strategic plan. The new SAG plan should be in place prior to the end of the current plan period.

Donor Partners. The USG is the largest financial contributor to South Africa's health sector, having provided a total of \$100 million direct support in 2004, most of which is for HIV and AIDS prevention, care and treatment. This commitment represents only 0.18 percent of the annual government expenditure for all health in 2003/04 but 68% of the SAG's expenditure specific to HIV and AIDS. The USG is one of many bilateral partners providing technical and financial resources to support the South African Strategic and Comprehensive Plans (19 are listed in the National Treasury donor inventory in June 2004). Other large donors include: the European Union, which reports a total contribution of €133.5 million over 5 years (including substantial direct budgetary support to the DOH and some dedicated HIV activities); the Global Fund, which has approved \$65,030,985 over two years; and DFID, which has invested €41,087 million in intervals ranging from 6 months to 5 years. The governments of Denmark, the Netherlands, Belgium, Australia, France, Sweden and Germany also are sizeable AIDS donors. Given the SAG's funding independence and its ability to manage policy in the health sector, the role of all international donors tends to focus on providing catalytic and complementary assistance to the public and private sectors.

The USG pays particular attention to Global Fund activities, seeking opportunities to complement Global Fund projects to increase program impact. In some instances (Soul City) the USG has leveraged bilateral donor and Global Fund investments; in others (KZN Consortium) the USG has provided technical assistance to enhance Global Fund implementation. Plans are well underway to develop an Emergency Plan activity that will complement the just-awarded Global Fund grant to the Western Cape Province.

Availability of Services: Health Care Infrastructure. South Africa's public health system is highly decentralized and provides health

care to about 80% of the population. While the nine Provincial Departments of Health are coordinated by the NDOH, they have constitutionally-based health responsibilities, direct funding, and considerable autonomy. Some health functions are further devolved to the municipal and district levels. Often the provincial and local levels provide important leadership and innovation.

Prior to 1994, the South African health system was based on apartheid ideology, characterized by severe racial and geographic disparities, a focus on hospital-based treatment, and segmentation into 14 separate departments of health. Since the advent of democracy, the SAG has made equity of health care access and service quality a priority through the creation of a nationwide district health system that emphasizes decentralized management, community participation, and provision of primary health care (PHC) services. Typically each district hospital is linked "down" to a network of community clinics and health facilities and "up" to larger district and provincial hospitals, creating networks of preventive and curative services. This approach has greatly increased access to PHC, especially for many historically disadvantaged citizens (see Appendix 4). A very capable national District Health Information System (DHIS) has been designed to move management and reporting information through the system, and is in operation at the district level. All laboratory services are overseen by the National Health Laboratory Services (NHLS), which provides services to the NDOH, including microbiological and virological testing. CD4 counts and viral load measurement is available at 144 NHLS-certified sites around the country. The South African Medicines Control Council provides high quality drug regulatory services and has been an effective government agency, whose actions influence the region and determine what ARV products are available for use in South Africa. As in most developing countries, the health care infrastructure varies widely in

different settings and regions, but generally urban areas have better resources. Overall, only ten percent of facilities lack sanitation, electricity and/or telephone service, and 20% lack piped water (NDOH, 2004).



Operating largely in parallel with the public sector, the private component of South Africa's health system has far more resources. The private health care system that serves 20% of the population accounts for 60% of the total health expenditures. There are, in a real sense, two South Africas, one reliant on the public health system, and one with access to diagnostic and treatment services on a par with any industrialized country. Global communications and state-of-the-art services, drugs, commodities and infrastructure are available to the few who can afford them; while the many who cannot are served with improving, but still insufficient, infrastructure and human capacity in the public sector. Some NGO health providers bridge this gap by bringing high quality care and reliable funding streams to service poor

and underserved areas. HIV and AIDS communication can reach the majority of households through well-developed mass media: 73% have radios and 54% have televisions; and, with 85% adult literacy, newspapers are numerous and widely read. World-class teaching hospitals also use both public and private sector resources for research, training, and service delivery. The extensive traditional medical system represents a third health care system, which is the provider of first resort for the majority of the population in many areas. The Comprehensive Plan recognizes traditional healers, with their conservative attitudes, community roots and successful herbal therapies for palliative care, as critical partners in South Africa's comprehensive response to HIV and AIDS.

Availability of Services: HIV and AIDS Services. The full spectrum of AIDS treatment and care services has been available in the private sector since their advent in the 1990s, and the government provided guidelines for these services early in this decade. National and targeted information and behavior change communication (BCC) campaigns through public service announcements (LoveLife and Khomanani campaigns) and commercial programs (Soul City; Tsha Tsha, Takalani Sesame) have broad penetration. A national school-based survey of youth found that 72.3% of learners report being taught about HIV and/or AIDS in school. Eighty percent of large employers (> 100 employees) and 6% of small employers have AIDS workplace policies and programs (NDOH 2004).

With the Strategic Plan, South Africa has moved toward the provision of expanded HIV and AIDS prevention, treatment and care services in the public as well as the private sectors (see Appendix 5). STI services are integrated into PHC, and free male condoms (plus 1.3 million female condoms in 2003) are available in PHC sites and are widely socially marketed and distributed in markets, shops and other sites (total 270 million in

2003). Programmatic interventions started and scaled-up in the last three years include PMTCT, HIV and AIDS voluntary counseling and testing (VCT), home-based care (HBC), non-occupational post-exposure prophylaxis, and the provision of antiretroviral therapy (ART). These services are delivered in both public and private health care facilities, and supported in mass media and community information and mobilization efforts. There are currently over 2,000 sites providing PMTCT services. HIV counseling and testing services are much more widely available in PMTCT sites and other public health facilities, and the SAG has a goal of making VCT universally available by 2005. The large VCT and PMTCT programs have helped set the stage for the scale-up of ART provision in the public sector, and there are currently 11,000 people on ART in the public system. National guidelines for VCT, PMTCT and HBC have been approved and are in use both in the private and public sectors. In addition, social support for OVC has received significant additional attention and funding through the DSD. However, there is still much to be done, especially in providing equitable access to health care, and scaling up ART and other programs.

Overall Policy Environment. South Africa's political commitment to providing quality health services for all is indicated by the SAG's investment in the health sector – which increased at an average of 14% per year from 1999. The South African Constitution and labor legislation provide some of the best protections in the world to address workplace and societal discrimination for those infected and affected by AIDS. They also provide citizens with legislative and judicial tools used to encourage a more rapid expansion of HIV and AIDS treatment and prevention services. Policies mandating universal primary and secondary education and affirmative action to promote university education lead to an educated workforce that is at lower risk of HIV. The SAG is introducing mechanisms to promote the equitable

availability of physician and nursing services to underserved populations such as a rural allowance to retain staff in rural facilities.

Key Socio-cultural Norms & Practices. South Africa's cultural diversity is a source of both strength and challenges. The politics of solidarity honed in the fight against apartheid have been directed toward the expansion of AIDS treatment and the provision of care for OVC. The values of extended families, social and tribal affiliations, and faith communities provide a social safety net. Nonetheless, many South Africans struggle to overcome the stigma associated with HIV and AIDS, to confront individual and societal AIDS denial, to address gender inequities and sexual violence that influence HIV transmission, and to deal with the problems associated with widespread poverty such as food insecurity, malnutrition and unemployment. In addition to other legacies of apartheid, large segments of South African society were denied higher-level educational opportunities, and for many the scientific paradigm that informs most HIV prevention and treatment strategies is not part of their world-view, limiting the impact of some "science-based" interventions. Many young people are sexually active early, and HIV prevalence rates by age groups clearly illustrate the need to change youth behavior: under 20 years, 15.8%; 20-24 years, 30.3%; 25-29 years, 35.4% (NDOH 2004b). Only 12.2% of learners perceived themselves at risk of HIV in their lifetime. Gender-based violence and sexual coercion that can influence HIV transmission are also widespread.

Since 1994, migration from bordering countries such as Mozambique and Zimbabwe has increased significantly, as has internal labor migration due to the attraction of relatively stable, high paying jobs in South African urban areas. As a result South Africa hosts one of the largest migrant populations in the world. The protracted separation from home involved in both cross-

border and internal labor migration is widely associated with having multiple sexual partners. Combined with poor living conditions, mobility is associated with weakened community and personal communication networks, substantial HIV stigma and denial, and sexual risk taking.

Government and Indigenous NGO Capacity.

The response to HIV and AIDS in South Africa has been an intensifying campaign led by the SAG and the non-governmental sector with an unprecedented commitment of human and financial resources. A vast network of NGOs/FBOs/CBOs and private industry are engaged in this effort, providing able partners for the donor community and the SAG. The South African National NGO Coalition estimates that there are at least 4,000 South African NGOs, CBOs and FBOs working in the development field. Some of these have been working in health and HIV for two decades. In rural areas and smaller cities and towns NGO/CBO/FBO capacity is more limited than in urban areas. Some provincial networks of PLWHA are strong and active but under-resourced. In the context of HIV and AIDS, the SAG has channeled significant national resources to NGOs, CBOs and FBOs for the delivery of key services, especially HBC, lay counseling, and services for OVC.

Because the Emergency Plan program will rely heavily on NGOs to provide services to rural and underserved populations, technical, management and resource-mobilization training will be provided to NGOs, in addition to financial support to strengthen their capacity. The USG will continue to mobilize additional resources to assist in NGO enhancement, such as deploying Peace Corps Volunteers and partnering with South African organizations skilled in NGO development. A number of NGOs in South Africa also have developed their own twinning relationships, and the USG team will encourage the growth and expansion of these relationships where they can

enhance HIV and AIDS programs. USG/SA also will consider whether the U.S.-based twinning center will provide cost-effective opportunities for South African Emergency Plan partners. The advantages of twinning also will be promoted by linking established organizations in the "two South Africas" for mentoring and support.

Section 1.3.3 Constraints and Opportunities for Emergency Plan Implementation

The constraints on and opportunities for implementation of the Emergency Plan in South Africa can be summarized as follows:

Enormous Scale of Interventions Required.

Over the next few years, South Africa will greatly increase the entire spectrum of HIV and AIDS interventions. The health system response must be scaled-up from providing ART to 56,000 people now to hundreds of thousands more, and will also have to cope with long-term support for the increasing numbers of patients on ART. At the same time, over one million orphans and perhaps millions of PLWHA will need access to social and health services by 2008. While the Emergency Plan will contribute substantial support to an integrated SAG program in all of these areas, the needs will exceed the services available. The challenge will be to scale-up the response with the most effective programs, to meet the human and system capacity demands, and to continue transformation of the health care and other systems so that the response is sustainable.

Emergency Plan and SAG Approaches Agree.

The SAG's Strategic and Comprehensive Plans mandate a balanced, integrated set of prevention, treatment and care interventions, with a strong emphasis on M&E. The SAG's approach focuses on strengthening the health care system as a whole, and increasing the integration of VCT, PMTCT, treatment and care into the PHC system. Implementation emphasizes enhanced public-

private partnerships and a network approach to service delivery. The harmony of South African and Emergency Plan goals and the unprecedented commitments of resources from both governments create real opportunities for collaborative and efficient programs.

South Africa is a Leader. While South Africa shares with other focus countries many resource constraints and social challenges, it has unique economic, educational and infrastructure advantages to contribute to Emergency Plan goals. Because of its leadership role in Africa, South Africa also is positioned to serve as a demonstration site for effective interventions and for dissemination of best practices. USG/SA will work to develop innovative approaches that will take advantage of South African capabilities and benefit Emergency Plan advancement as a whole.

SECTION 2: CRITICAL INTERVENTIONS

Section 2.1 Introduction

In keeping with the priorities of the SAG, the USG/SA's Emergency Plan objectives are:

1. To prevent new HIV infections;
2. To expand access to HIV treatment;
3. To provide palliative care for people living with HIV;
4. To provide care for orphans and vulnerable children; and
5. To strengthen the South African public health system and increase equity of access to high-quality health care to help achieve HIV and AIDS objectives.³

³ The mission of the SAG health system is: "To improve health status through prevention and promotion of healthy lifestyles and to consistently improve the health care delivery system by focusing on access, equity, efficiency, quality and sustainability." Strategic Priorities for the National Health System 2004-2009, p. 4

The USG and the SAG will achieve our shared objectives through a collaborative, flexible, and rigorously monitored and evaluated strategy defined by seven principles.

Principle 1: Support the SAG Program. A cardinal principle of the USG program in South Africa is that Emergency Plan implementation coordinates with the overall strategy defined by the SAG's Strategic Plan and the Comprehensive Plan. The USG will consult and collaborate with SAG counterparts at national, provincial and district levels, ensuring programs are culturally acceptable, and adapting tools and approaches to local needs. The USG will sponsor interventions that support and are integrated into the health service delivery system, leveraging the public health system and strengthening its capacity and quality to make services more widely accessible, designed to reduce stigma, and user-friendly. The same principle will inform USG collaboration with other elements of the SAG, including Education, Social Development, Correctional Services and Defense. Provincial governments are particularly important as they have primary responsibility for implementing significant portions of the Comprehensive Plan. All USG implementing partners obtain approval from provincial and district health officials before initiating activities, and all partners maintain regular dialog with local government counterparts to ensure that project activities reflect local needs and priorities.

Principle 2: USG Integration. All USG agencies that have HIV program capabilities in South Africa, including Department of State, USAID, HHS (CDC, NIH), the Department of Defense and Peace Corps collaborate and coordinate internally through a highly-effective inter-USG-agency Task Force, the Steering Committee of which is chaired by the Ambassador. This Task Force plans and integrates programs, allocates funds, shares information, manages all Emergency Plan activities, and works through specific USG

agencies according to their comparative advantages. The Task Force also provides the SAG with a unified point of liaison for all USG collaboration and assistance on HIV and AIDS.

In addition to direct funding through the USG/SA country program, the USG/SA is fortunate to have a small number of Track One (centrally-awarded and funded) grantees active in the areas of treatment, OVC, safe medical practices and blood safety. It is anticipated that additional centrally-funded awards promoting prevention for youth (ABY) and care for OVC will be awarded, with funding additive to that planned for locally produced projects. After initial review in Washington or Atlanta, all centrally-funded proposals undergo a thorough local review and approval process involving the potential grantee, the Task Force and the SAG. Through this process the USG and the SAG ensure that centrally-awarded programs fit within the SAG's Strategic and Comprehensive Plans and the USG/SA Strategy.

Principle 3: Many and Diverse Partners. To maximize the geographic reach and programmatic impact of the USG contribution, the USG/SA HIV program works with diverse governmental partners and all levels of the public health system. In addition, Emergency Plan partners in South Africa include local and international private companies, NGOs, CBOs, FBOs, foundations and philanthropic organizations, "bilateral" donors, the Global Fund, U.N. Agencies, PLWHA groups, professional organizations, trade unions, academic institutions, and traditional healers.

The USG/SA team has made it a priority to attract new partners. Through an innovative inter-agency APS, over 400 South African NGOs/CBOs/FBOs and private companies applied to become Emergency Plan partners. Many are highly qualified and submitted innovative ideas with promising plans for long-term sustainability. In

2004, five government departments, led by the NDOH, and over 40 local non-governmental, faith-based and academic organizations have become partners in the South Africa Emergency Plan effort. In addition, nearly 20 international non-governmental organizations are involved with local partners in program service delivery. For FY05 and the remaining years of the Emergency Plan, additional new partners will be identified and incorporated into the program depending on the availability of resources.



Public-private partnerships are an area where South Africa has important comparative advantages. SAG policy encourages such partnerships and the South African private sector has demonstrated a capacity to support HIV and AIDS prevention, treatment and care. Emergency Plan support will promote public-private partnerships to bring sustainable resource flows into health system networks, and to promote sharing of private sector management and service capabilities. Private employers and insurers introduced AIDS care and ART as early as 2000, and the USG is engaged in expanding partnerships to harness this expertise and experience. Additional innovative programs involve U.S. and local trade unions working

together to provide integrated HIV and AIDS services to union members and their families. Private sector technical capacity, such as satellite-based communications systems, is also harnessed in support of public health programs.

In order to effectively implement South Africa's program nationwide and through multiple partners, the USG will ensure consistency by requiring our partners to conform to the detailed and excellent standards and guidelines promulgated by the SAG. South Africa provides strong leadership and direction on matters ranging from technical standards of care, to staff training requirements, to quality assurance standards and levels of stipends. The USG will also convene periodic meetings with partners and SAG officials to ensure SAG standards are being uniformly maintained. Across partners, the USG will support the development of best practices, and will work to facilitate the exchange of best practices by sponsoring regular meetings among our partners as a whole and in thematic working groups, as well as sharing information through a common web-based interface established pursuant to the overall USG data warehouse and website project.

Principle 4: Evidence-based Programming. In consultation with the SAG and other local experts, the USG will continue to develop the Emergency Plan program on research-based evidence of success and effectiveness. The Emergency Plan will prioritize services for vulnerable and underserved populations identified through epidemiological research, such as women and girls, youth, incarcerated persons, and mobile populations. Emergency Plan-supported treatment and prevention activities also will contribute to achievement of SAG human rights and non-discrimination objectives using "best practices" models developed in South Africa and internationally. Implementing other best-practices models will also help ensure a continuum of care that links VCT and PMTCT with treatment and

other HIV services. Findings from all targeted evaluations will be broadly and openly shared to inform policy makers, program managers, communities and other stakeholders. The USG/SA team will also seek opportunities to identify, document and disseminate promising South African models and tools to promote consistency, avoid duplication, and maximize use of resources.

Principle 5: Measurable Results. All interventions supported by the USG will be rigorously measured through regular reporting and targeted studies, according to universal standards and indicators used by the SAG and the Emergency Plan. Funding and technical assistance will be provided to ensure all USG-supported activities are well documented and monitored, and that strategic information is analyzed and used, both to account for resources and to strengthen service delivery. Future funding allocations to partners will be based in part on their proven ability to use funds effectively and contribute to SAG and Emergency Plan goals.

Principle 6: Capacity Development. Capacity building is a cornerstone of USG/SA's Emergency Plan program. The USG will continue to support diverse and complementary approaches to build the capacity of our partners, establish networks among service providers, and strengthen the capacity of the health system. These activities will: (1) enhance the skills of existing implementers through technical assistance, the deployment of Peace Corps Volunteers and focused training and exchange interventions; (2) augment the number of trained people; and (3) support improved practice through access to knowledge, updated policies, needed tools, and supportive management and information systems.

Principle 7: Sustainability. USG/SA investments will: (1) ensure that technical innovations and standards become routine practice; (2) build the management, administrative, and technical

capabilities and systems of implementing bodies (governmental and non-governmental); (3) assure planning to secure diversified and renewable financing; and (4) build continued support at the policy level. Given the resources available in South Africa, the potential for overall program sustainability in five years is high. For each partner, the USG requires a sustainability plan, and in particular the USG encourages its international partners to make plans in order to turn their activities over to local implementers at the end of their funding terms.

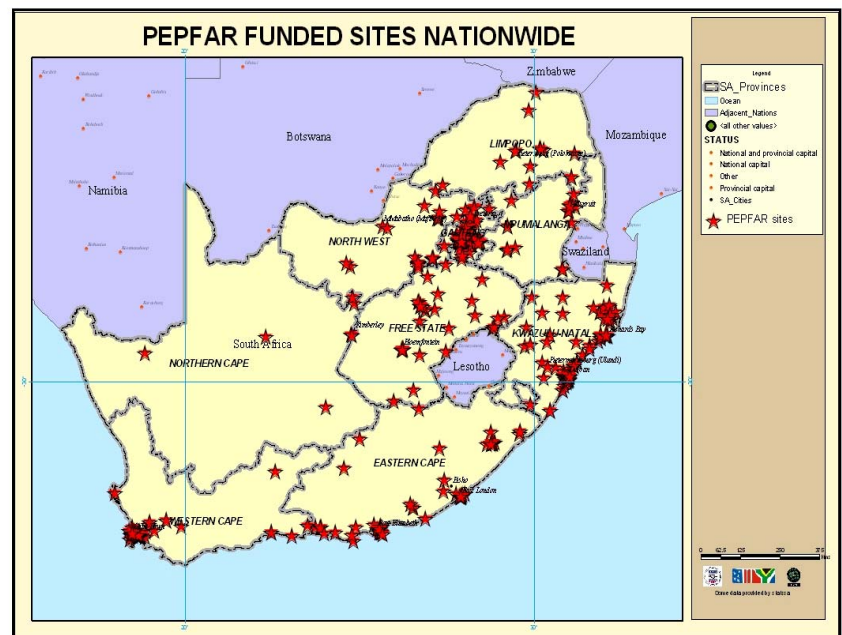
In supporting programs that advance these seven principles, the USG also will take the following considerations into account.

Allocation of Emergency Plan Resources. In supporting the SAG's Comprehensive Plan, the USG/SA will commit the largest share of resources to providing AIDS treatment and related services and activities, through increasing the capacity of the public health system and supporting NGOs. USG/SA will work closely with SAG and other partners to achieve program funding allocations in accordance with the guidance contained in the enabling legislation for the Emergency Plan.⁴

⁴ The USG/SA will strive to achieve the legislative goal of not less than 55% of assistance expended "for therapeutic medical care of individuals infected with HIV." Medical care for HIV-infected persons includes ARV treatment, integrated wellness programs, and treatment of OIs and TB. Because the SAG has committed to the nationwide purchase of ARV drugs, including drugs used by many Emergency Plan partners operating in the public health system, USG/SA does not anticipate expending the recommended 75% of the support for ARV treatment on ARV drugs, allowing the efficient achievement of increased numbers of patients treated.

Geographic Distribution. South Africa has a generalized epidemic, and the Minister of Health has specifically requested the USG to provide HIV and AIDS program support in all nine provinces. The USG will focus on certain provinces due to their higher prevalence levels (e.g. Eastern Cape, Gauteng and KwaZulu-Natal) and on others due to their human capacity or other resource needs. The USG/SA will support the SAG's comprehensive, nationwide program, and its aim of achieving equity in access, by strengthening organizations with national reach, and by giving priority to underserved communities when designing

Figure 2: Distribution of Emergency Plan activities



interventions. Consistent with the Emergency Plan, the USG/SA also will select interventions located where HIV prevalence and risk factors are high in order to have the greatest impact on care, treatment and prevention goals (see Figure 2). The USG will continue to work with implementing partners that can access high-risk and underserved populations, such as incarcerated

persons, and that will assist the UNHCR to provide HIV and AIDS services to refugees and asylum-seekers.

Regional Partnerships. The USG/SA strategy incorporates an important linkage and collaborative relationship with the USAID Regional HIV/AIDS Program (RHAP) for Southern Africa and the Regional CDC Office for Southern Africa. The Emergency Plan strategy relates directly to these offices' strategic objectives that include "Increased access to services in high transmission border communities." Collaboration with regional office initiatives complements activities focused on facilitating behavior change, and strengthening care and support initiatives located in high-prevalence, high-mobility border areas with high concentrations of at-risk people. Linking the RHAP and CDC regional efforts with USG/SA programs will leverage additional (non-Emergency Plan) program resources, and will continue to build international consensus on this collaborative international approach to public health action.

Comparative Advantage. The USG will support activities that utilize USG agencies' and partners' comparative advantages in working with the NGO and private sectors, in strategic information, in facilitating technical dialog and policy updates, and in management, quality assurance, supply chain, logistics, and other support systems.

Quality Assurance. The USG/SA will continue to support quality assurance capabilities and systems that improve client and staff satisfaction and system performance essential to maximizing results. For example, USG/SA support will incorporate QA into training on ART and palliative care; enhance monitoring of compliance with guidelines and standards in VCT, PMTCT, TB/HIV and ART; expand quality control of drugs, test kits and other commodities in health facilities; and strengthen referral systems that are key to the network model.

Program Management. Although often not included as a "program element," strengthening partner program management is indispensable to including additional and more diverse NGOs, CBOs and FBOs into Emergency Plan program implementation. The NDOH has requested that Emergency Plan resources support management strengthening at the provincial level. In addition, USG staff and partners will develop and promote the use of clinical service management and operational management tools and systems to help ensure that management capabilities keep pace with the expanding need for information and services.

Support Supply Chain Management. The Emergency Plan will support efforts to provide a full supply of safe and effective drugs and related test-kits and supplies at the lowest possible cost to support the ARV rollout and other elements of HIV and AIDS care. Historically, an essential component of USG assistance has been to strengthen the capacity of the health system to distribute, track, store and dispense drugs and other commodities. The SAG recognizes the USG comparative advantage in supply chain management and has requested Emergency Plan assistance to support the expansion of ART in public sector facilities. USG supply chain assistance will include strengthening capacities at the national, provincial, district and municipal levels in procurement, distribution and management of commodities, strengthening pharmaceutical services; training of pharmacists and others responsible for supply chains; and developing logistics systems. This supply chain management support will extend beyond ART to reach non-traditional outlets and high-risk settings with condoms, OI drugs and other public health necessities. Once the USG has awarded an overall supply chain management contract pursuant to the recent USAID solicitation, the USG/SA will examine the services offered to

determine how the South Africa program can use that tool effectively.

Strategic Information and Applied Research.

Selected targeted evaluations and operational research are critical to strengthening and expanding HIV and AIDS services in all program areas. Due to the sophistication of South Africa's research capacity there are significant opportunities for the USG to work with the SAG and to coordinate and collaborate with other donors in supporting important studies needed to guide policy and improve HIV and AIDS prevention, treatment and care. The USG/SA will leverage NIH-supported studies, CDC surveillance expertise, and other technical resources to identify strategies and opportunities that can improve programs, and that will enable policy makers to stay informed about the evolving HIV crisis. In each case, the USG will seek to link supported studies with future improvements in service delivery.

Strengthen Laboratory Capacity and Infrastructure.

The NICD is expanding HIV and AIDS, STI and TB laboratory activities to keep pace with rapidly growing diagnostic and treatment needs. The Emergency Plan will assist in these endeavors in order to improve national surveillance for HIV infection and TB, and to strengthen the capacity of NICD, provincial, and other local public health laboratories to diagnose these diseases which are critical to prevention, treatment and care. To support the expansion of VCT sites and services needed for the Comprehensive Plan, the USG will assist the NDOH to expand quality assurance and laboratory support for rapid test kits to assure the accuracy and quality of testing services. The USG will also support the NICD in monitoring ARV resistance, as ART sustainability depends on efficacy of available drug therapies. Generally, South Africa has excellent public and private medical laboratory facilities. Therefore, the SAG has not requested USG support for the

development of laboratory capacity. If the SAG requests additional assistance with laboratory development during the Emergency Plan, the USG will be prepared to provide assistance with that effort.

Section 2.2 Prevention

The SAG's strong focus on averting new HIV infections and the near universal awareness of the threat of HIV provide a solid foundation for prevention activities. Declining syphilis rates in antenatal settings suggest STI services in PHC have improved, providing a model for success in addressing HIV. Increased political commitment and the engagement of national leaders have helped to advance public debate and to bring additional partners into the response. In addition, developments in prevention science, endorsed by the SAG, encourage integrating HIV prevention into treatment and care to boost the effectiveness of each. This recognition of the benefits from integrated programming expands opportunities for prevention in health facilities, and promises to increase the effectiveness of BCC.

The challenges of HIV prevention are underscored by recent HIV surveillance findings indicating that, despite the national HIV program and widespread awareness of HIV and AIDS, HIV prevalence continues to rise. Since AIDS prevention efforts in some workplaces and sectors are still limited to annual sensitization events on World AIDS Day, expanding integrated BCC requires innovation and perseverance. The availability, uptake and effectiveness of HIV and AIDS information and services, including PMTCT services, are reduced by continued stigma, discrimination, denial and gender inequality.

In this environment, the Emergency Plan will assist South Africa to avert over 1.3 million HIV infections by 2008 through a broad-based prevention program. Many activities will follow the

ABC model, encouraging abstinence and faithfulness with appropriate target audiences, while also providing condoms for populations at risk. The USG will strengthen community involvement and support sustainable interventions including: PMTCT; programs to reduce HIV risk among youth through promoting abstinence and faithfulness; prevention for the general public; prevention for high-risk populations; promotion of blood safety; and prevention of transmission in medical settings.

Section 2.2.1 PMTCT

The availability of effective interventions to prevent mother-to-child transmission of HIV provides hope to communities affected by AIDS, motivates adults to accept HIV counseling and testing, and makes a small but important impact on HIV prevention goals and targets.⁵ As of July 2004, the national coverage of PMTCT services averaged about 55% among the nine provinces, with some provinces achieving almost universal coverage. The NDOH PMTCT program intends to achieve universal coverage for the remaining provinces by March 2005. In addition to wide



coverage, the Emergency Plan and SAG strategy

⁵ Prevention of HIV in infants (who are unlikely to infect others) has limited impact on the spread of HIV, but enormous impact on families, communities, and health providers.

is to ensure that PMTCT is integrated into routine antenatal care accessed by 85% of pregnant women. The goal is for all pregnant women to be offered VCT, and to receive a full complement of services if they test HIV-positive.

Increase Access to PMTCT Services. The USG/SA will support the SAG program to increase the number of facilities where PMTCT is available by providing technical and infrastructure capacity building, including training for providers at all levels of the health care system.

Improve Quality of PMTCT Programs. The USG will use a wide variety of strategies to improve PMTCT quality, such as implementing SAG approved drug protocols and assisting with the development of protocols for related areas, such as infant feeding. The SAG is currently considering changes to its policy of nevirapine monotherapy. If new guidelines are adopted, the USG will ensure that our partners comply with the most current standards. Emergency Plan activities will further ensure that NDOH policies for PMTCT are applied at the provincial level, and will support the improvement of PMTCT information and management systems, applying these systems to provincial level PMTCT efforts and supporting training to collect, analyze and utilize strategic information in support of quality services.

Increase Awareness and Demand for PMTCT Services in Identified Areas. Community mobilization and peer education approaches will be used to promote awareness of the benefits of PMTCT services, to encourage partner involvement, and build support for women or couples who use PMTCT services. Increasing positive support and reducing negative social outcomes will lead to increased demand and use. The USG will continue to support a wide variety of programs designed to improve uptake of PMTCT services, including promoting linkages with VCT and treatment programs implementing the

Comprehensive Plan.

Integrate PMTCT Service Components into Routine MCH Services and Other HIV Services.

To support the SAG's efforts to integrate PMTCT services with other primary health care services, the USG will support increased linkages among PMTCT, family planning and essential maternal and neonatal health care. USG programs will encourage the uptake of VCT during pregnancy as well as enhancements to complement PMTCT services, such as integrating post-delivery health services for HIV positive mothers and HIV-exposed infants into PHC systems. The USG will also explore options to integrate ART into PMTCT programs and ANC so that there is a continuum of care available to mothers and infants with HIV.

Section 2.2.2 Abstinence, Be faithful for Youth

Improve A/B Preventive Behaviors among Youth. As in most countries, youth in South Africa are subject to a variety of conflicting social messages and influences related to sex. Delaying first sexual intercourse by even a year can have a significant impact on the health and well being of adolescents. The USG will support school programs that address youth sexuality, co-factors to HIV transmission, and life skills to delay sexual debut. The USG will also support community programs to reach out-of-school youth with similar messaging. Discussion of gender issues, economic pressures, basic information about care and treatment in prevention, and young people's roles in providing care and support, will be encouraged in these programs. Youth/child clubs and other youth/child-centered activities will foster environments that reinforce age appropriate life skills. Programs that promote messages to increase faithfulness and secondary abstinence will be targeted to sexually active audiences.

Increase Effective Mass Media Approaches and CBO/FBO Activities. USG programs will reach

youth through mass media efforts as well as through programs that strengthen the capacity of CBOs and FBOs to provide appropriate outreach and support. Materials and programs will model healthy attitudes and behaviors, addressing underlying social and behavioral norms that contribute to HIV transmission, especially peer pressure, intergenerational sex and sexual coercion and rape. Emergency Plan supported ABY programs will be evidence-based, reflecting research on the target populations and products tested with appropriately segmented target populations. These programs will be integrated across projects to facilitate harmonization of BCC messages, and to ensure these messages are echoed in care and treatment counseling, in schools, churches and mosques, and in other influential settings.

Section 2.2.3 Prevention for Other Populations

Youth interventions are most successful when they are reinforced in the broader health communication environment, and by parents and other adults. USG supports programs that can provide these role models with appropriate skills while addressing significant transmission among adults, including South Africa's skilled workforce.

Increase Preventive Practices by Increasing Quality Prevention Services for Adults.

Emergency Plan programs will use integrated, multi-media, multi-channel communication and skills building approaches to raise risk perception and to promote preventive practices, such as partner reduction and fidelity among adults. The USG will continue to support substantial mass-media programs that have proven to have broad audiences and impact, while also seeking local support for the continuation and sustainability of these programs.

Empowerment approaches will link directly to individual and social action, and to the social and

economic drivers of infection. Interventions will provide skills for personal risk assessment and risk reduction planning, and promote social support to enable HIV-negative clients to remain uninfected and HIV-positive clients to access support and services. Special attention will be given to prevention for HIV-positive individuals, and to couples counseling. USG efforts will strengthen the national condom logistics system to ensure that SAG's public sector distribution efforts are optimized, and that discordant couples have access to barrier methods. Interventions will increase quality and access to integrated prevention, treatment and care information, and VCT services.

Reduce Infections in High-risk Areas and among Vulnerable and High-risk Populations.

Evidence-based programming will lead Emergency Plan partners to build on and scale-up successful programs in high transmission areas and programs that involve and serve populations at high-risk, including mobile populations, women surviving through transactional sex, and the uniformed services. USG programs will support services for communities that are especially vulnerable to continued HIV transmission due to current high prevalence rates, underlying socio-economic strife and/or geographic proximity to mobile populations like truck drivers and miners. Audience segmentation and supply chain expertise will be used to develop enhanced and targeted condom social marketing for high-risk settings. Care and treatment services, and especially VCT and STI treatment, will be promoted where they are available. Because there is a lack of good data regarding certain high-risk populations, the USG will conduct an assessment of the HIV risk of vulnerable populations such as MSM and drug-using populations, and will develop a plan for reaching these populations.

Mobilize Communities and Support FBOs/CBOs to Increase Prevention Services.

The USG will promote integrated technical and management training to enable more FBOs and CBOs to provide technically sound HIV and AIDS prevention services. Models and tools for religion specific spiritual and value-based HIV prevention activities will be developed and shared. Interventions to reach parents, adult caregivers and mentors will be supported to address their role in guiding youth and providing supportive environments to reduce high-risk behaviors. Leveraging sustainable resources and addressing stigma, discrimination and gender will receive special attention. Messages and dialogue will be included to combat underlying social and behavioral norms that contribute to HIV transmission, especially intergenerational sex, violence, sexual coercion and rape. Collaboration and information sharing will be encouraged to strengthen links between mass media, clinical and community interventions, and to include traditional leaders and healers.

Increase Workplace Programs to Educate the South African Labor Force.

The USG will use its many links to businesses in South Africa to promote the expansion of initiatives to reach South Africa's critical skilled workforce. Emergency Plan partners will work with business coalitions, training centers and chambers of commerce to develop and implement strategies to help businesses provide effective HIV and AIDS services for their employees. Many of these initiatives will be supported through public-private partnerships, such as integrated workplace programs that offer prevention and VCT services through associations with workplace organizations, teachers unions, other trade unions and the military. The USG will also support the integration of prevention with comprehensive AIDS services by private companies, and will support adoption of sound HIV policies and expansion of HIV prevention messages by small and medium enterprises.

Section 2.2.4 Blood Safety

Increase Supply of Safe Blood by Enhancing Blood Transfusion Services. The SANBS provides a successful blood safety program; all blood is routinely screened for HIV-1 and 2, hepatitis B and C and syphilis. SANBS actively recruits voluntary blood donors and educates the public about blood safety, including educating prospective donors about who can and cannot be a blood donor by helping them assess if they have medical conditions and high-risk behaviors that prevent blood donations. The USG will provide training in management, operations and monitoring of blood supply to expand the SANBS capacity and enhance its sustainability. As a part of the USG's integrated program, messages regarding integrated prevention, treatment and care will be incorporated into blood donor programs, and blood safety issues will be addressed in HIV and AIDS communication programs. In addition, assistance will be provided to SANBS to establish training programs for South Africa and other African countries.

South Africa...has unique economic, educational and infrastructure advantages to contribute to Emergency Plan goals.

Section 2.2.5 Other Medical Transmission of HIV

Build Capacity in Safe Injection Practices and Medical Waste Management. While medical transmission of HIV is not thought to be a major factor in South Africa, improving injection practices and waste management contribute to strengthening the PHC system. Medical

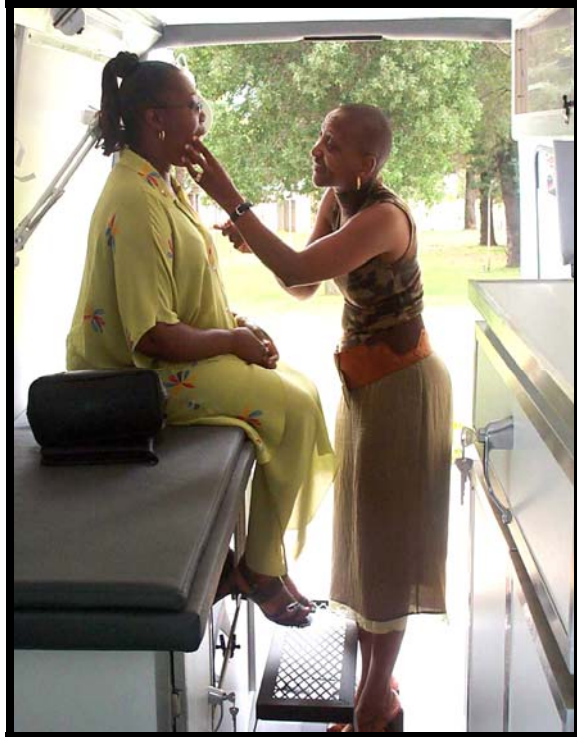
transmission interventions also will be designed and implemented in collaboration with traditional health practitioners who often use techniques exposing them and their clients to bodily fluids. USG assistance will promote national policies that support injection safety and sharps waste management. These issues will be incorporated in pre-service and post-service training to strengthen health care worker skills, and into health facilities management and supply chain logistics and management training.

Section 2.3 Treatment

The Comprehensive Plan calls for the rapid nationwide expansion of AIDS treatment services in South Africa, including the use of ART.⁶ Through this extraordinary program, more people will receive ART in South Africa over the next four years than are currently using this therapy throughout the rest of the world. The challenges to the rollout range from building human capacity and managing complicated logistics and laboratory support to changing behaviors and ensuring widespread access to services. The Emergency Plan goal is to provide ART treatment services to more than 35,000 patients in FY05 and substantially more in successive years. To meet these goals, the USG will support the SAG's program to increase access to high quality ART in an equitable and sustainable manner by using three major approaches: (1) increasing the capacity of the National and Provincial Departments of Health to develop, manage and evaluate AIDS treatment programs; (2) scaling-up existing pilot programs in low-resource and workplace settings and initiating new ones, training health care workers, and enhancing the supply chain management systems to respond to treatment expansion; and (3) increasing the

⁶ The SAG views care and treatment for women and families through PMTCT as an integral part of broader care and treatment efforts, and therefore does not consider PMTCT+ services to be a distinct program area.

demand for and acceptance and reliable use of ARV treatment through mass communication campaigns, client education, and community mobilization.



Expand Access to ART Services for Adults and Children. The Emergency Plan will support the expansion of VCT, wellness and ART services in major public hospitals, and other public and private treatment sites. In addition to capacity building, PHC public and NGO treatment sites will be supported to link them both “upward” to hospitals and “downward” to the community, strengthening and expanding the network system within larger service areas. Supported projects will provide ART to HIV-infected children, and the USG will expand additional programs in areas such as early infant diagnosis and referral to further scale-up access for children.

Build Capacity for ART Service Delivery. Training in both technical approaches and

management systems is vital to expanding and sustaining ART services. Emergency Plan resources will assist the national public- and private-sector rollout through developing and expanding existing training and quality assurance programs, both for those who will deliver ART and related services and for those who will supervise and manage the ART services. The USG will promote best practices and engage a variety of NGO, academic and private sector organizations in this effort. The USG will also support the development of models that can be replicated widely in different settings, including in the private sector.

Increase the Demand for and Acceptance of ARV Treatment. The USG will promote treatment literacy, adherence and community mobilization through mass communication efforts and targeted communication strategies coordinated with other elements of the behavior change program. Emergency Plan-funded mass communication programs will be synchronized with provincial efforts to scale up ART. Adherence will be reinforced beginning with effective counseling by trained health workers when treatment begins and followed by ongoing community support. USG efforts will include mobilizing community leaders, traditional healers, FBOS and CBOs into sustainable networks that provide psychosocial and material support.

Section 2.4 Care

HIV and AIDS care involves a continuum of services for individuals and their families from the time of infection through to hospice and bereavement support. VCT provides a critical entry point, and permits wellness/positive living interventions that can delay a PLWHA's decline and postpone the need for ART. With 5.6 million PLWHA today, the central challenge of HIV and AIDS care in South Africa is to strengthen the array of capacities and systems that will provide the

needed mix of accessible and effective basic clinical, social development and community services.

Section 2.4.1 Counseling and Testing

VCT for HIV is a critical gateway to appropriate prevention, treatment, care and support services for those infected and affected by HIV and AIDS.⁷ VCT promotes and sustains behavior change, and is a core component of interventions such as PMTCT, HBC, and post-exposure prophylaxis, and should be included in services for the prevention and treatment of TB and other OIs. VCT is also a crucial tool in efforts to reduce the spread of STIs. Since 2000 the NDOH has supported widespread implementation of a national counseling and testing program, established policies, procedures, guidelines and protocols, and has legislated intervention strategies, all of which provide opportunities for further scale-up of VCT. For example, couples counseling has been shown to be more effective than individual counseling in helping people make long-term behavior changes. It is aimed at helping the couple to discuss together changes in sexual behavior as well as plan together for their dependents, with help and support from their counselor at both pre and post-test counseling sessions. In 2002 the NDOH developed a three day course for both trainers and counselors entitled "Couple Counseling in an HIV/AIDS Context" and Guidelines for Couple Counseling. Couples counseling is currently being provided at all VCT sites. With Emergency Plan support the

current training materials will be revised and submitted as an official SAG course, increasing the numbers of couples seeking counseling and testing, knowing their status and addressing issues of sero-discordance and sero-disclosure. There are over 3,000 counseling and testing sites located throughout the country, 80-90% of which are part of diagnostic testing within clinical settings. The SAG national HIV and AIDS strategy seeks to provide universal access to an adult population between the ages of 15-49 through public and non-governmental sector partnerships by the end of 2005. The Emergency Plan will assist the SAG to increase access, while improving quality and use of VCT.

In order to reach substantial treatment targets, the USG will work with the SAG to expand counseling and testing services in all areas, and will ensure that all partners are aware of the critical importance of proper referrals for effective support and treatment. Without the expansion of counseling and testing, ambitious treatment targets cannot be reached.

Expand Access and Availability of VCT Services. The fact that most HIV VCT sites are health facility based constrains their accessibility, user-friendliness and use, especially for rural communities and among men and youth. In order to move beyond the 3,000 primary health centers with VCT services, the USG will assist the SAG to implement programmatic approaches to expand VCT reach through targeted services and social marketing. The USG will also collaborate to expand workplace promotion of VCT and prevention services by integrating VCT information and education within the context of life skills education. Additional expansion of VCT services will be supported through NGOs, CBOs and FBOs to reach traditionally underserved populations, including incarcerated individuals, the military and persons living in rural areas, at both static and mobile facilities. The USG will collaborate with the

⁷ The SAG uses the term VCT for the full suite of informed, client-focused pre- and post-test counseling, testing, and referral in clinical and community settings, while others promote the term "counseling and testing" (CT) for this broad array of services. This semantic difference is not to be confused with the important policy issues regarding 'opt in' versus 'opt out' VCT, and regarding routine diagnostic testing with or without informed consent and counseling. These issues are now being considered and debated in South Africa. In this document we follow SAG usage when referring to programs in South Africa.

South African National Defense Force (SANDF) to train health care workers to provide PMTCT, VCT and related preventive and counseling and services in the military.



Increase Demand for and Use of VCT Service. The USG will support programs that increase the uptake of VCT by integrating VCT into other health care delivery and by decreasing stigma and discrimination. To support the SAG's VCT initiative, USG's BCC activities will also promote the normalization of knowing one's HIV status and support campaigns to "stay negative."

Strengthen National VCT Policy and Infrastructure. USG agencies will provide ongoing technical assistance to the NDOH to support VCT policy and infrastructure and to refine and update VCT guidelines, policies and strategies. Trainings on the latest guidelines will be supported in collaboration with the SAG, and assistance will be offered to maintain high levels of adherence to guidance and protocols. The SAG has developed standards for HIV counseling for all individuals and organizations providing HIV counseling. Coordination of training activities will occur through the sharing of training schedules to all USG agencies and ensuring that all partners implementing HIV counseling and testing have access to the same training and training materials. Additional USG support will strengthen laboratory support to assure the accuracy of testing services and strengthen data collection and M&E systems.

Accurate site-specific information will help design programs to reach emerging high-risk populations and to ensure the maintenance of quality programs and referrals.

Increase VCT Services' Links with and Referrals to Health Systems Networks. As new VCT sites are made available and mobile testing units come into use, linkages between VCT and other prevention, care, and treatment services will be strengthened, particularly in rural areas. VCT programs will ensure that clients testing HIV-positive are supported to access referral networks for TB and home-based/palliative care. Both HIV-positive and HIV-negative clients will be assisted through access to counseling and community support. These services will be provided independently and/or jointly with private sector organizations, NGOs and CBOs. In addition, the USG will continue to collaborate with the NDOH to integrate VCT into existing primary health services by collaborating with the TB, PMTCT and STI programs to ensure VCT services are available as a routine part of clinical services.

Section 2.4.2 Palliative Care

Over 500,000 HIV-positive South Africans have illnesses or symptoms requiring clinical care, but not yet warranting ART. Many are co-infected with TB or have opportunistic infections. In this context, the NDOH highlights the essential role of good palliative care, from promotion of wellness after diagnosis, to good nutrition and pain management, bereavement and end of life care. The NDOH also encourages public-private partnerships, from the hospital ("step down care") to community level HBC that constitutes a network to provide a full circle of care for PLWHA and their families. While palliative care encompasses a broad array of services, the most urgent challenge is to expand community level systems to provide for the needs of PLWHA, keeping up with the inexorable growth in needs over the next decade.

Increase NGO/CBO/FBO Capacity to Deliver Quality HBC. Recognizing a responsibility to PLWHA after they are discharged from the hospital, the NDOH has scaled up HBC programs, and has developed a national HBC policy that is in wide use. The USG will promote the adoption of these best practices by Emergency Plan implementing partners, and will support CBO/FBO/NGO capacity to plan, implement and evaluate palliative and home-based care programs for adults and children. To help them sustain their invaluable service, USG HBC programs will ensure HBC volunteers receive supervision, recognition, and technical support within the network.

Expand Access to Quality Palliative Care Services. The Emergency Plan will support programs to increase the range of providers of palliative care services, and will promote the expansion of quality hospice services nationwide. The USG will also support the expansion of clinical care for patients not enrolled in a treatment program, and will support the strengthening of the health care system to support this goal. In expanding care services, the USG will also increase the involvement of PLWHA and promote support groups for PLWHA.

Improve Quality of Palliative Care and HBC Services. The Emergency Plan will enable the USG to expand current SA palliative care training institutions at the provincial and national levels, and ensure that national quality training standards are maintained and disseminated. Where needed to complement a network's staff, the USG will support training in all ranges of care, including TB care, as well as improving the distribution of essential palliative care medicines and commodities. The USG will support the NDOH to finalize a policy and guidelines for quality palliative care, and to disseminate this and the HBC policy to all levels of the network. The Emergency Plan will also support wellness programs that delay the onset of AIDS and the need for ART. USG

programs will develop appropriate tools and systems for monitoring quality and reporting quantities of care provided.

Promote Linkages to Integrate Care Services into the Health Delivery System. A critical goal of palliative care services is to identify people who are ready for treatment and refer them to the relevant treatment service providers. Many patients receiving ARV treatment are also receiving care for OIs and other related services. For these reasons, care services are closely integrated with ARV services and with other HIV services. Integrated management by USG partners will promote linkages to prevention and treatment services, and USG programs will also support early management of OIs and strengthening referral systems. The Emergency Plan will support the development of strategic information and communication needed to link these basic care services "downward" to HBC and "upward" to secondary and tertiary services.

Strengthen TB/HIV Services and their Integration into HIV and PHC Services.

Tuberculosis is the leading cause of death among HIV-infected individuals, and 55% of TB patients are co-infected with HIV. Diagnosis and treatment of concurrent TB disease constitutes a substantial part of HIV and AIDS care. Effective management of TB in the HIV-infected population will not only decrease morbidity and mortality in these individuals, but also prevent the spread of TB infection to others. Accordingly, the USG intends to provide significant support to TB/HIV programs.

Many TB interventions are incorporated into programs providing care for HIV-positive individuals with a range of opportunistic infections. For example, Emergency Plan-funded PMTCT activities will follow NDOH guidelines for the "Management of HIV-Positive Pregnant Women and PMTCT." These guidelines include provisions for screening all HIV-positive women for signs and

symptoms of active TB with referral to appropriate ART and TB service sites. All Emergency Plan supported programs will follow SAG guidelines that promote HIV counseling and testing for all suspected TB cases. The USG will seek to strengthen integrated TB/HIV program activities, increasing access to diagnostic HIV counseling and testing among TB patients and evaluation for HIV care, including ART. The Emergency Plan will provide funding to HIV VCT and care settings to screen for active TB among HIV positive clients, improve their referral and case holding systems, and improve their capacity for HIV surveillance among TB patients. Best-practices models will be developed to integrate approaches to TB/HIV management, with the overall goal to optimize care of HIV-infected TB patients. The USG will also support enhancement of the TB information system and national TB reference laboratory.

Section 2.4.3 Care for Orphans and Vulnerable Children

Strengthening the capacity of communities to respond to HIV and AIDS will continue to be an important component of the South African response to meet the needs of OVC. Improving services for children, child-headed households and orphans affected and infected by HIV and AIDS and other communicable diseases is a top strategic objective for the SAG. DSD has built



capacity, expanded training and developed strong working relationships with numerous stakeholders including CBOs, FBOs, NGOs, private sector companies and labor to assist in service delivery. By 2003, DSD reported supporting 314 centers for home-based care and identifying 75,000 children as orphaned or vulnerable due to HIV and eligible to receive services. The USG target is to provide direct OVC services to over 150,000 OVC in FY05. Meeting substantially greater needs over the next five years will require joint effort and creativity of all the USG's existing and new public and private sector partners.

Expand CBO/FBO/NGO and Community Capacity to Deliver Quality Care. Emergency Plan programs will improve the knowledge and skills of FBOs, CBOs and NGOs to provide care, support and counseling to OVC and the households supporting them, in order to strengthen the capacity of families to cope with OVC challenges. These programs will identify and test innovative care models with CBOs and faith-based OVC practitioners, replicate successes, and build sustainability by engaging new partners and leveraging public-private partnerships. Special attention will be given to service delivery in under-resourced communities, and to the special needs of girl children. Programs to support caregivers will also be encouraged. To achieve a multiplier effect, larger NGOs/CBOs/FBOs will be used as umbrella mechanism(s) providing grant funding and technical assistance to smaller indigenous CBOs/FBOs.

Increase OVC Access to Government Support and to Income Generating Activities. The SAG provides important benefits to OVC, and the Emergency Plan will support programs that utilize existing partners and communication channels, including district HIV and AIDS service networks, to facilitate access to these programs, particularly support grants, education and health services. USG programs will also promote the welfare of

OVC by supporting training for food production and programs that promote income-generating activities.

Expand Linkages and Referral Systems with Other Health and Social Services.

Linkages of OVC programs to HIV and other health services will be strengthened to keep HIV-negative children healthy and to meet the needs of HIV-positive children. USG programs will collaborate and leverage resources of other USG-supported economic development, education and food security initiatives, those of the SAG, and the activities of other donors, to provide additional services to OVC and their communities.

Strengthen and Expand OVC Policies and Guidelines. The USG will assist the DSD to communicate policy and guidelines regarding OVC programs (such as bereavement, child-headed households, and access to social services) to NGOs, CBOs and communities so that all may apply best practices and assess services against clear standards. The USG will also strengthen the national coordinating structure by funding provincial structures to monitor and coordinate the OVC response and the quality of services provided.

**SECTION 3:
SUPPORTIVE INTERVENTIONS**

Section 3.1 Engendering Bold Leadership

Leadership in South Africa comes from South Africans. In implementing the Emergency Plan, the USG follows the advice and direction of South African leaders in government, civil society and the private sector, while supporting leadership efforts that reduce stigma, promote HIV and AIDS awareness, recognize the severity of the epidemic, and commit all sectors of society to the AIDS struggle.

Government Financial Commitment. South Africa has developed and financed one of the largest, most comprehensive HIV and AIDS programs in the world. Significant national resources have been budgeted for provincial health directorates and for the DSD (for OVC programs), the Department of Education (for ABY-oriented activities), as well as the NDOH. Over the medium term (2002-06), the National Treasury projects that South Africa's HIV and AIDS funding allocation will total R8.5 billion (US\$ 1.31 billion), giving a clear indication of government leadership and a growing commitment to comprehensive HIV management and care.

Leaders in Government, Civil Society and the Private Sector. In addition to government financial commitment, many of the country's most prominent citizens, including former President Nelson Mandela, Archbishop Desmond Tutu, Zulu Prince Mangosuthu Buthelezi, Vice President Jacob Zuma, and key industrial leaders have spoken forcefully and often on the importance of expanding HIV and AIDS prevention, treatment and care programs. Their leadership has helped focus public attention on the problems of stigma and discrimination and they have attracted international partners who have provided additional resources for private sector programs. Civil society organizations have a record of accomplishment in mobilizing locally and using South Africa's democratic institutions and free press to advocate for expanded, equitable access to AIDS treatment and care and support. South Africans have provided global leadership and collaboration with multilateral efforts to make effective AIDS drugs affordable and available in *all* developing countries.

Some major utilities and industries are demonstrating leadership in analyzing and publicizing the impact of AIDS outside of the health sector, and by identifying the comparative advantage various sectors have in the national

response. The South African pharmaceutical industry includes responsible innovator companies as well as licensed generic drug manufacturers. Several companies have made major investments to be able to produce and market safe, effective and affordable ARV drugs, consistent with the requirements of the TRIPS agreement. In addition the SAG Medicines Control Council works closely with the FDA, and it is likely that products from South African companies will be among the first generic ARVs and FDCs approved for Emergency Plan purchase. These companies have been forthcoming in dealing with USG/SA, and they have made a social as well as a business commitment to making quality drugs widely available and affordable to help treat AIDS globally.

Traditional and Faith-Based Leaders.

Historically, some religious leaders, primarily at the national level, have been very active in garnering public attention and support for the development of a comprehensive national HIV program. While some elements of the religious community have been slow to respond to the AIDS crisis, many religious leaders are now becoming more focused on HIV related needs of their congregations. In implementing the Emergency Plan, USG/SA will emphasize the involvement of faith-based groups to foster hope and help implement grass-roots programs for prevention and care.



Community leaders including parents, teachers, and health care providers will play key roles as change agents and advocates to encourage community mobilization to combat HIV and to support those infected and affected. Special initiatives will receive Emergency Plan support to reach traditional leaders and healers as well as the leaders of all faith communities. Effective approaches will be shared with and implemented in other communities.

Section 3.2 Stigma and Discrimination

Stigma, discrimination and denial present constant challenges to any HIV program. The expansion of ART availability may have an impact on these, but it is still far too common for HIV and AIDS to be seen as shameful and for disclosure to be dangerous. In October 1998, then-Deputy President Thabo Mbeki launched the Partnership Against AIDS, calling on all South Africans to join in the fight by talking openly about HIV, working actively to de-stigmatize it, and uniting in the search for a vaccine and a cure.

Changing community attitudes at the grass-roots level can mitigate the stigma surrounding HIV and AIDS. USG-supported approaches to combat stigma will include: (1) involving opinion leaders (including PLWHA leaders) and popular, trusted individuals in communications campaigns, including mass media; (2) targeted behavior change interventions; (3) promoting the integration of HIV and AIDS services into the primary health care delivery system; (4) involving PLWHA leaders in program development and implementation – both to incorporate their perspectives and to provide them with a visible platform; and (4) developing evidence-based guidelines and tools that offer practical steps to overcome stigma and enhance support for PLWHA in workplaces, faith-based organizations, and the media. The USG has been a key supporter of the Greater Involvement of

People Living with HIV and AIDS (GIPA) principle since 1994. Current Emergency Plan programs involve PLWHA groups in care and treatment programs, and the USG will continue to look for appropriate opportunities for substantial involvement by PLWHA in our partners' activities. Additionally, the USG will continue to support activities that will increase the capacity of local indigenous organizations, FBOs and traditional healers to promote stigma mitigation.

The USG has also funded dialog and research in South Africa to identify effective approaches to combating HIV and AIDS stigma, which has defined the importance of "accepting environments," access to factual information, and good pre- and post-test counseling both in healing the emotional trauma of HIV infection, and in promoting positive living. This research will be applied to the development of practical guidelines for stigma reduction by FBOs, in workplaces, and in media representations of HIV and AIDS and PLWHA, and will provide ideas and approaches to be integrated into many Emergency Plan activities, from the development of training curricula for health service providers to the messages conveyed in HIV communication interventions.

Section 3.3 Gender Equity

Sexual violence and gender inequities drive the spread of HIV in South Africa, and enhancing gender norms and equity are critical factors in enabling responsible sexual behavior. Women continue to have higher infection rates than men; in the 15-24 age bracket, 77% of those infected are women. Men who are infected are at a disadvantage in terms of care and treatment, as they reach services much later in the disease trajectory. Most VCT services are offered in antenatal care clinics that do not cater to the needs of men. Similarly, many ANC sites do not attempt to reach the male partner with VCT services. For 30,000 women tested at one Emergency Plan

partner's ANC sites, fewer than 20 men were reached.

In recognition of the role that gender plays in the spread of HIV, the USG incorporates gender as an overarching theme in many programs. Activities have been strategically planned at two levels – those aimed at changing behavior within society and those directed at improving service delivery. For example, life skills and workplace programs include important gender messages particularly to decrease community tolerance of gender violence, and these messages are reinforced through mass media. At the point of service delivery, many USG projects are designed to take gender into account by, for example, incorporating gender modules into training for service providers. Emergency Plan programs also address changing attitudes of men and attitudes towards men.

Section 3.4 Achieving Sustainability and Human Capacity Development

Even were HIV transmission to stop today, South Africa's health system needs will dramatically increase as more asymptomatic people progress to disease. Public health care institutions already are stressed often to the breaking point by the burden of diseases associated with poverty and HIV infection. While there are well-trained and committed health workers at all levels in the public and private systems, human capacity is perhaps the most severe constraint facing South Africa. Because the human capacity crisis in South Africa could derail all other efforts to combat HIV and AIDS, the Emergency Plan must commit substantial resources to address these needs.

Despite its relatively high GNP and per capita income, South Africa has significant health service delivery capacity constraints, particularly in rural areas and in the public health sector. While

South Africa has many well trained and dedicated health professionals in the public sector, NGO, and academic settings, there are too few personnel resources to provide the needed services on an adequate scale. South Africa trains many providers, but a very large proportion are drawn to the private sector, or emigrate in search of higher pay or better working conditions. Overall, only 40% of health facilities have primary care nurses, and only 30% are visited by a doctor at least weekly (NDOH 2004c). In many public clinics and hospitals health professional vacancy rates are 30-50%. Without concerted action this problem will get worse, as 17% of health workers are HIV-positive. Aside from the sheer numbers of needed providers, skills and management need to be strengthened both to incorporate new ideas and therapies, and to improve service quality.

The NDOH Comprehensive Plan specifies a need for 6,233 additional medical officers, professional nurses, enrolled nurses, assistant nurses, pharmacists, pharmacist assistants, dietitians/nutritionists, social workers, lay counselors and community health workers, and administrative clerks by March 2005. The number balloons to 13,805 by March 2008. Capacity development also is needed to integrate traditional practitioners into the AIDS care and treatment system.

The USG plan is to assist in capacity development at all levels while working with the SAG to help develop strategies to improve recruitment and retention of critical staff. USG/SA will take advantage of all available tools, including the high quality training available in South Africa, as well as centrally-funded Emergency Plan initiatives. The USG will collaborate with the SAG and private sector partners to provide training to 60,000 people in FY05. The goal of all HCD activities will be to: (1) enhance the skills of existing implementers; (2) augment the number of skilled people; and (3) support improved practices

through access to knowledge, updated policies, needed tools, and supportive management and information systems. Emergency Plan supported training will enable more sites to absorb and administer expanded resources, to ensure services meet local needs and are sustainable, and to integrate and ensure cost-effective performance. Training will be supported in all areas from clinical skills to management services, from strategic information and M&E systems to quality assurance, from supply chain management to communications technology. The Emergency Plan will also support training in research and BCC to develop social and behavioral interventions and communication messages that promote healthier behavior in individuals and mobilize communities to effectively utilize AIDS treatment and care services.

In each programmatic and geographic area, Emergency Plan supported training will be tailored to specific needs and designed to enhance capacity to provide effective services and reach Emergency Plan targets. In all cases, the USG training strategy will contribute to the overall training strategy of the SAG, which is based on comprehensive needs assessments in different sectors. These trainings may be pre-service or in-service, short or long-term as the circumstances require. The USG will support trainings of doctors, nurses and lay counselors. For example, human capacity to support the nationwide ARV rollout varies from province to province, and the USG will support appropriate trainings and support to develop all provinces' capabilities to provide ARV treatment.

Section 3.5 Strengthening Coordination and Collaboration

A U.S.-South Africa Joint Consultation Group, chaired by the NDOH, oversees planning and implementation of the Emergency Plan program. Beginning in October 2003, Emergency

Plan implementation in South Africa has proceeded with regular meetings of this group, involving six SAG departments. No other bilateral relationship involves such intense and continuing intergovernmental consultations, demonstrating the unique commitment the SAG has made to assure the success of the Emergency Plan. In addition, USG grantees and contractors consult regularly with appropriate SAG counterparts at each government level to ensure projects are consistent with government policies and priorities. Through this network of collaboration with the SAG, the USG will continue to provide any requested assistance in the development of national policies and standards.

Other external donor coordination is directed by the SAG through SANAC and through quarterly meetings of a Donor Forum, co-chaired by the NDOH and UNAIDS. The USG will also continue to develop collaborations with donors active in HIV and AIDS (such as DFID and the EU), with recipients of Global Fund grants, and with UNAIDS and other multilateral organizations.

Global health, in particular HIV and AIDS, is the top priority in the U.S. Mission Performance Plan, and USG representatives raise the issue in diplomatic and technical exchanges with government and with private sector partners while pursuing Mission objectives such as trade and investment, strengthening regional security, enhancing mutual understanding and improving democratic systems and practices. With its multisectoral development mandate, USAID integrates HIV and AIDS into all its program areas, leveraging non-HIV funds for education, economic growth and job creation, democracy and governance, and housing and environment to help forward HIV and AIDS goals. Emergency Plan HIV/TB initiatives are designed to be complementary to USAID TB initiatives. The USG team also looks for opportunities to enhance Emergency Plan programming by using lessons

learned from NIH-funded research programs in South Africa, and by funding local NIH research partners to provide AIDS and OI treatment services.

3.6 Strategic Information

Monitoring and evaluation is a priority under the SAG Strategic Plan and an equally high priority in Emergency Plan programs. The SAG is committed to implementing a strengthened and sustainable M&E system by 2008 that will: (1) monitor the status of HIV and AIDS; (2) inform policy development; (3) identify effective public health and social responses; and (4) ensure successful program performance. In pursuit of these goals, the NDOH has reviewed and developed HIV and AIDS indicators and disseminated a set of core indicators for South Africa, and developed and implemented the District Health Information System (DHIS) database for routine monitoring of indicators for all public health system programs. The NDOH has also trained HIV staff on M&E, data management and the national health information system. Following the "three ones" approach to M&E and to assure SI program coordination, the USG/SA M&E team has initiated an ongoing program of consultations with SAG counterparts.

Although significant steps have been taken toward achieving SAG M&E goals, the comprehensive nature of the national HIV program, the rapid evolution of HIV and AIDS technical areas, the large number of partners involved in HIV and AIDS service network implementation, and the resulting diverse demands on the M&E system, require a staged approach to designing and implementing an upgraded and integrated M&E system. A recurrent challenge is balancing the urgent needs for management and reporting data on specific HIV and AIDS interventions (such as quarterly Emergency Plan reporting, beginning in 2004) with the NDOH's objective of integrating HIV

into the existing health system. A longer-term challenge is to manage the data flow from district to province to national DOH and ensure the quality of that data at each level. Through collaboration and assistance to the SAG and strengthening implementing partners' strategic information systems, the Emergency Plan will help the SAG address these challenges and progressively ensure that the South African national strategic information system achieves its goals by 2008.

Enhanced collection of information for program monitoring and surveillance. The USG/SA will assist the SAG in assessing and prioritizing information needs for tracking HIV and AIDS and measuring its impact. The USG also will support national biological and behavioral surveillance efforts by: (1) aiding the SAG to make full use of its national surveillance system; (2) filling data gaps (e.g. HIV incidence, population-based mortality); (3) analyzing and synthesizing data to support SAG HIV and AIDS indicators and to answer program and policy questions; and (4) assessing the potential impact of new interventions and changes in HIV transmission cofactors (e.g., male circumcision). Pending needed expansions of the DHIS to cover new data needs in the area of AIDS treatment and care, the USG will fund periodic facility based surveys, and will facilitate aggregation and reporting of data from private sector and NGO partners to provide both the SAG and the USG with critical information on service delivery.

National Coordination of M&E Programs. Now that the DHIS database has been designed and implemented at the district level, the data aggregation and analysis components of the system will be strengthened to facilitate flows of information from the district through the provincial to the central levels. The NDOH is emphasizing training and systems strengthening to build M&E capacity at each level and to improve integration between them. The USG goal is to complement

SAG systems and to promote information flow between levels of the system, and between all components of the service delivery networks in order to enhance integrated prevention, treatment and care. A similar issue identified by the Monitoring, Evaluation and Research (MER) unit is a need for further coordination of M&E activities within NDOH. Due to the rapid scale-up of programming and the critical need for information, many of the program areas have developed parallel databases or whole M&E systems. The USG will support the NDOH in harmonizing these efforts.

Emergency Plan Implementing Partners. The Emergency Plan strategy will promote coordination, standardization and collaboration among USG-funded projects, and information sharing and alignment with SAG counterparts and partners. The Emergency Plan emphasizes M&E capacity and effort, and standardization with Emergency Plan indicators. The USG will strengthen reporting through a data warehouse and website project that will facilitate: (1) timely aggregation and analysis of data from private sector, public sector and NGO partners, (2) information sharing with the SAG (e.g. contributing to UNGASS indicators) and (3) reporting through the COPRS to OGAC. The USG has set high standards for program monitoring and reporting for its implementing partners, and is supporting capacity building and technical assistance to ensure that partners meet these standards.

SECTION 4: CONCLUSION

South Africa meets the essential conditions for Emergency Plan success: a strong government commitment to partnership at all levels, a tradition of public involvement and government transparency, a public and private health care network that can implement an effort of this magnitude, a robust academic environment, and a large pool of committed partners including

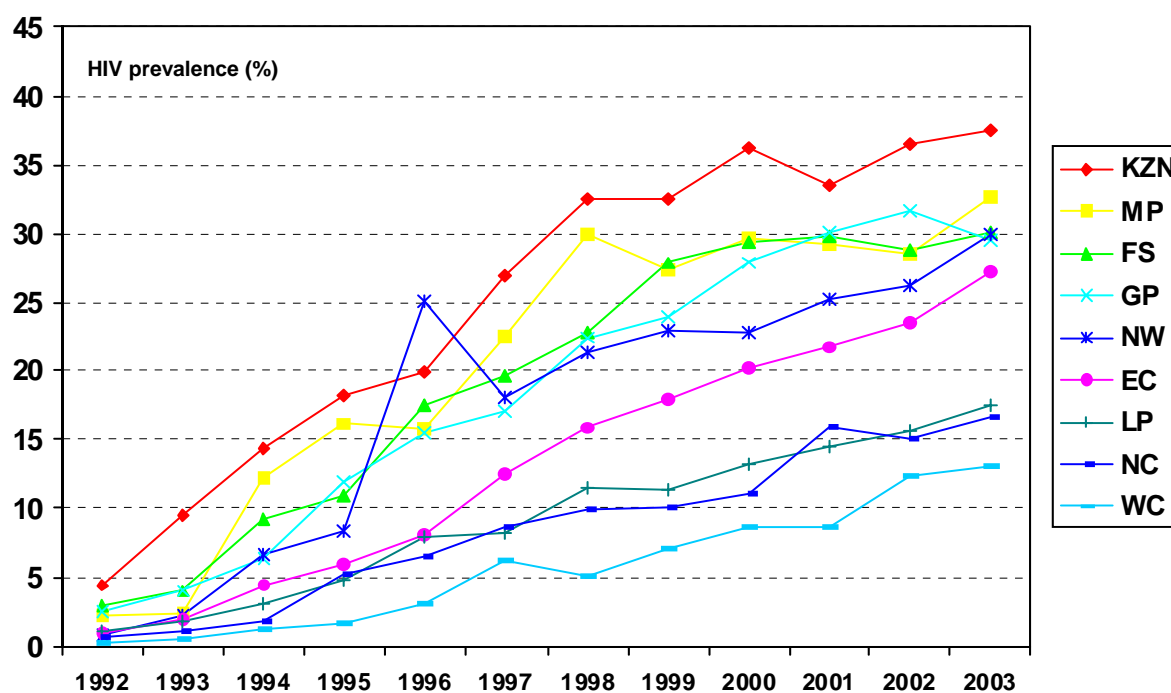
NGOs, FBOs and private businesses. South Africa can fully utilize, efficiently and cost-effectively, all the Emergency Plan resources allocated to it in order to make substantial contributions toward Emergency Plan goals and toward improving the lives of thousands of South Africans.

Appendix 1: The Sociodemographic and Economic Context in South Africa

Area (sq mi)	471,444	Gross Domestic Product (Market prices, 2003) ^	\$160 Billion
Population estimate* (mid-2004)	46.9 mil.	Per capita GDP (US\$) in 2003/4 (market prices)	\$3443
Percent below 15 years of age*	34%	Percent urban*	53%
Dependency Ratio**	61%	% Government Expenditure on health^^	11.3%
Life expectancy at birth (male; female)*	53 years (49-57)	Percent below the poverty line (range among provinces)	40% (7.5 – 66.5%)
Infant mortality rate++	43 per 1,000 live births	Percent employed in the formal sector^^^	65%
Total Fertility Rate	2.8 children/women	MDs per 100,000 pop, 2003 (range among provinces)	19.7 (12.7 31.9)
Contraceptive Prevalence+++	61.2%	Adult literacy rate***	85%
Immunization Rate+	82%	Human Development Index, 2001 (and rank) ~	0.68 (111)

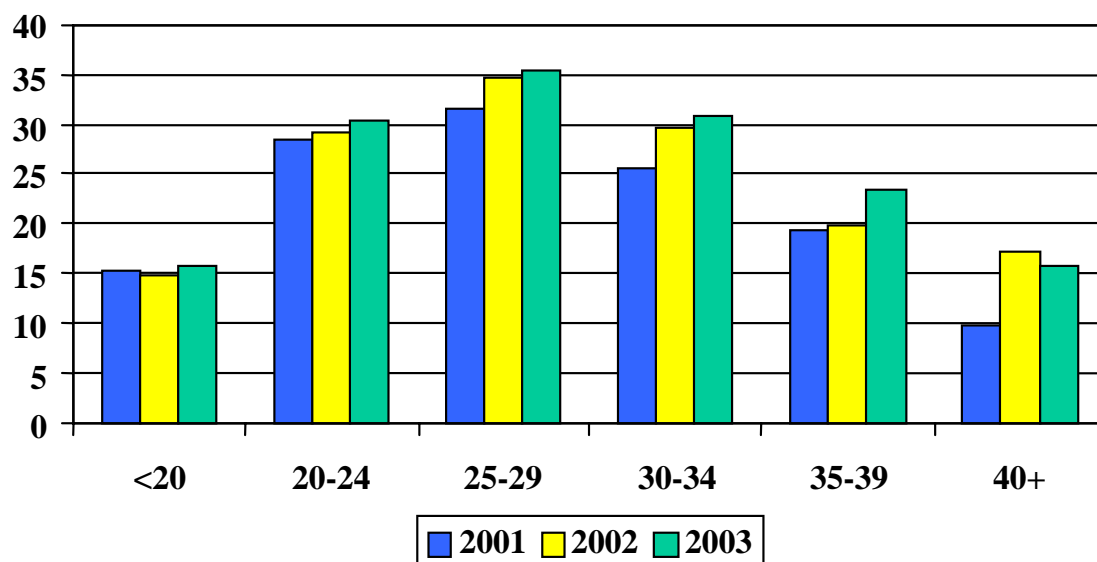
*1 data are from the 2004 World Population Data Sheet (Population Reference Bureau) ; **calculated based on 2004 World Population Data Sheet (Population Reference Bureau); *** UNICEF ; + NDOH 2004 Strategic Priorities for the Health System; ++South African Health Review, 2003/04; +++ 1998 DHS; ^ Quarterly Bulletin SARB, Sept 2004; ^^ 2004 Budget Review: 144; ^^^ Work Force Survey, March 2004 ; SAG 2003, Presidency D; ~ Human Development Report 2003

Appendix 2: HIV Prevalence by Province, Antenatal Surveillance, South Africa 1992-2003



Sources: NDOH 2002, NDOH 2004b

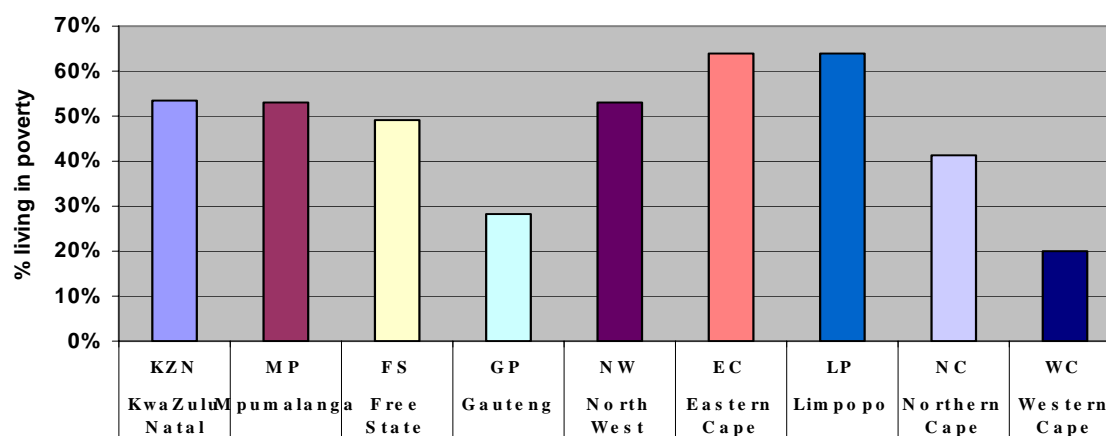
Appendix 3: Age-specific HIV prevalence in South Africa 2001 -2003 indicating stabilized incidence of HIV*



*The prevalence of HIV in antenatal women is often used as a proxy indicator for incidence of HIV (rate of new)

Source: NDOH (2004c): National Antenatal

Appendix 4: Persons living in poverty by province, South Africa 2001



Source: DRI-WEFA,
South Africa

Appendix 5: Availability of HIV and AIDS Services in 2003/2004

Facilities providing VCT	2582 ⁺
People receiving HIV counseling (public sector):	300,000 ⁺
Proportion accepting testing after counseling:	70% ⁺
Learners who have received HIV education at school	72% [*]
Public facilities providing PMTCT	1,652 ⁺
Public facilities providing HBC	893 ⁺
Individuals on ART (public & private):	56,000 ⁺⁺
Individuals on ART in USG/SA directly supported programs:	4,934 ⁺⁺⁺

Sources and years of data: * NDOH 2003b, National Youth Risk Behavior Survey; ** NDOH 2003 Antenatal Surveillance; + NDOH 2004 Annual Report; ++Figure combines 11,000 on ART in the public sector (NDOH, October 2004) and 45,000 on ART in the private sector (HST, October 2004, personal communication); +++ USG/SA figures as of Sept 30, 2004

Appendix 6: References Cited

- Auvert, B., Ballard, R. and Campbell, C.E.A. 2001. High prevalence of HIV infection among youth in a South African mining town is associated with HSV-2 seropositivity and sexual behaviour. *AIDS*. 15(7): p. 885-98.
- Bachmann O.M., and Booysen L.R.F.. 2003. Health and Economic Impact of HIV/AIDS on South African Households: a cohort study. *BMC Public Health*, 3:14.
- Barnett, T. and Whiteside, A. 2002. *AIDS in the Twenty-First Century. Disease and Globalization*. New York. Palgrave Macmillan.
- Blecher M., Thomas S.. Health care financing. In Ijumba P, Day C, Ntuli A. South African Health Review 2003/04. Durban: Health Systems Trust 2004. <http://www.hst.org.za/publications/423/>.
- Bradshaw, D., Bourne D., Nannan N.. 2003. What are the leading causes of death among South African children? MRC Policy Brief. No3, December 2003.
- Dorrington R., Bourne D., Bradshaw D., Laubscher R., Timeaeus I.M.. 2001. The Impact of HIV/AIDS on Adult Mortality in South Africa. Cape Town. South African Medical Research Council.
- Garbus, L. 2002. HIV/AIDS in South Africa. Country AIDS Policy Analysis Project. AIDS Policy Research Centre. San Francisco: University of California San Francisco.
- Goyer K.C.. 2002. Prisons. AIDS Brief for Sectoral Planners and Managers. Health Economics and HIV/AIDS Research Division. Durban. University of Natal.
- Henry J. Kaiser Family Foundation. 2001. Impending Catastrophe Revisited. An update on the HIV/AIDS Epidemic in South Africa. Johannesburg. Henry J. Kaiser Family Foundation.
- Hickey A., Ndlovu N., Guthrie T.. 2003. Budgeting for HIV/AIDS in South Africa: Report on intergovernmental funding flows for an integrated response in the social sector. Cape Town, South Africa. IDASA – Budget Information Service.
- Horizons. 2004. Vulnerability and Intervention Opportunities: Research Findings on Youth and HIV/AIDS in South Africa.
- Ijumba P., Poole C., George G., Gray A.. Access to Antiretroviral Therapy. Chapter 23 in Ijumba P, Day C, Ntuli A. South African Health Review 2003/04. Durban: Health Systems Trust 2004. <http://www.hst.org.za/publications/423/>.
- Kramer S. 2002. Life Assurance Industry. AIDS Brief for Sectoral Planners and Managers. Health Economics and HIV/AIDS Research Division. Durban. University of Natal.
- Masango D. 2004. Fight Stigma Against HIV, Aids. BuaNews. Pretoria. <http://allafrica.com/stories/200410110381.html>
- Measure Evaluation. 2004. Transitions to Adulthood in the Context of HIV/AIDS in South Africa. University of Kwazulu-Natal, Durban, South Africa. Tulane University, New Orleans, LA, USA.
- NDOH (National Department of Health). 2000. HIV/AIDS and STI Strategic Plan for South Africa, 2000-2005. Pretoria: South African National Department of Health
- NDOH (National Department of Health). 2002. ANC Surveillance Report. National HIV and Syphilis Antenatal Sero-prevalence Survey in South Africa. 2003. Pretoria: South African National Department of Health.

NDOH (National Department of Health). 2003a. Operational Plan for Comprehensive HIV and Care, Management and Treatment for South Africa. 2003. Department of Health, South Africa.

NDOH (National Department of Health). 2003b. The 1st South African National Youth Risk Behaviour Survey. November 2003. Pretoria: South African National Department of Health.

NDOH (National Department of Health). 2004a. Annual Report. Department of Health 2003/04. Pretoria: South African National Department of Health.

NDOH (National Department of Health). 2004b. ANC Surveillance Report. National HIV and Syphilis Antenatal Sero-prevalence Survey in South Africa. 2003. Pretoria: South African National Department of Health.

NDOH (National Department of Health). 2004c. Strategic Priorities for the National Health System. Pretoria: South African National Department of Health.

Office of the United States Global AIDS Coordinator. 2004. HIV/AIDS. Country Profile.

Office of the United States Global AIDS Coordinator. 2004b. The President's Emergency Plan for AIDS Relief. U.S. 5-Year Global HIV/AIDS Strategy. Washington DC, U.S. Department of State.

Partners for Health Reform Plus. 2004. Synthesis of Findings from NHA Studies in Twenty-Six Countries.

PERSAL Personnel Administration System. Extracted 2003-19-30.

Pettifor, A, Rees, H, Stevens, A. 2004. HIV & Sexual Behavior Among Young South Africans: A National Survey of 15-24 Year Olds, University of Witwatersrand.

Population Reference Bureau. 2004. World Population Data Sheet. Washington D.C.. Population Reference Bureau.

Reddy P, et al. 2003. Programming for HIV Prevention in South African Schools. Horizons Research Summary. Washington, D.C.: Population Council.

SARA (Support for Analysis and Research in Africa) Project. 2003. The Health Sector Human Resource Crisis in Africa. An Issues Paper. Wasington, D.C.. The SARA Project.

Shisana O., Hall E., Maluleke K.R., Stoker D.J., Schwabe C., Colvin M., Chauveau J., Botha C., Gumede T., Fomundam H., Shaikh N., Rehle T., Udjo E., Grisselquist D.. 2002. The Impact of HIV/AIDS on the Health Sector. National Survey of Health Personnel, Ambulatory and Hospitalized Patients and Health Facilities, 2002. Pretoria. National Department of Health.

Shisana O. and Simbayi L.. 2002. Nelson Mandela/HSRC Study of HIV/AIDS, South African National HIV Prevalence, Behavioural Risks and Mass Media. Cape Town. The Human Sciences Research Council.

Siyam'kela. 2002. HIV/AIDS-related stigma: A literature review. Cape Town. Policy Project, South Africa, Centre for the Study of AIDS, University of Pretoria, USAID, and Chief Directorate: HIV/AIDS & TB, Department of Health.

Siyam'kela. 2002. HIV/AIDS-related stigma: A tool for measuring the progress of HIV/AIDS stigma mitigation. Cape Town. Policy Project, South Africa, Centre for the Study of AIDS, University of Pretoria, USAID, and Chief Directorate: HIV/AIDS & TB, Department of Health.

South African Government. 2003a. Toward a Ten Year Review: Synthesis Report on Implementation of Government Programs. The Presidency, South African Government.

South African Government. 2003b. Toward Ten Years of Freedom. Progress in the First Decade; Challenges of the Second Decade. The Presidency, South African Government.

Statistics South Africa: Statistical release PO302 Mid-year estimates. (various years) <http://www.statssa.gov.za/>.

UNAIDS/WHO. 2004 Update. Epidemiological Fact Sheets on HIV/AIDS and Sexuality Transmitted Infections.

UNAIDS. 2004. HIV/AIDS in South Africa. July 2004.

UNDP (United Nations Development Programme). 2003. Human Development Report: Millennium Development Goals: A compact among nations to end human poverty. New York: United Nations Development Programme 2003. <http://www.undp.org/hdr2003/>.

UNICEF, 2003a. The State of the World's Children 2004. Girls, Education and Development. New York. UNICEF. December 2003.

UNICEF 2003b. Africa's Orphaned Generations. New York. UNICEF. November 2003.

USAID/South Africa. 2003. USAID HIV/AIDS Strategy 2003. Pretoria. U.S. Agency for International Development.

US Bureau of the Census 2000. HIV/AIDS in South Africa.